[Entered at the Post Office at St. Louis, Mo., as Second Class Mail Matter.]

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Vol. XXXVIII. Number 6.

March 20, 1880.

THE SAINT LOUIS
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THE USE OF DEXTRO-QUININE IN INTERMITTENT FEVER

Case.	Name and sex of patient.	Age.	Number of paroxysms before Taking.	No. of par. since taken.	Dose and mode of Exhibition.	Exhibited. Total amount.	Remarks, Pathological and Physiological Phenomena, Etc.	Reported by.
85	J. W. D., male. *Quotidian.*	63	3	0	2 grs every two hours.	14 gr.	It was a case of slow fever, which had terminated in a quotidian intermittent. Patient had taken quinine at times for the past 35 years. No unpleasant symptoms or ringing in the head from his *Dextro-Quinine*. N. B.—This patient was opposed to quinine, as he insisted that it always produced unpleasant symptoms and ringing in his ears, but he admitted that he experienced no unpleasant symptoms from the *Dextro-Quinine*.	T. G. Comstock, M.D., Good Samaritan Hospital, St. Louis Mo.

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Yours very respectfully,

T. G. COMSTOCK M. D."

102	James C., male, *Tertian Ague.*	17	3 months	0	20 grs. in 5 gr. doses during intermission.	20 gr.	Had taken cinchonidia repeatedly but it kept returning. Severe tinnitus aurium. No return in six weeks	D. H. Chase, M. D., Hoosier Prairie, Clay county, Ill.
103	Mary W., female. *Tertian.*	10	5 months	0	15 grs in 4 doses day before the paroxysm.	25 gr.	Did not complain of quinism. No return in 4 weeks.	D. H. Chase, M. D., Hoosier Prairie, Clay county, Ill.
104	J. M., female. *Quotidian*	3	3	0	6 grs. in 2 doses during intermission.	6 grs	Was active determination to brain and spasms during the fever; but the *Dextro-Quinine* did not affect the head. Well now for six weeks.	D. H. Chase, M. D., Hoosier Prairie. Clay county, Ill.
105	M. Carragan, male.	13	2	0	3 grains every 2 hrs. until 3 doses only were given on the evening before the coming chill in the morning.	9	After taking the second powder he began to perspire freely. Could not stand Sulph. Quinine. No unpleasantness from the DEXTRO-QUININE. This case was treated by the sample sent to me by mail. It worked like a charm. Shall give it a fair trial.	H. L. Cokenower, M. D., Pleasant Plains Ill.
123	William Tannahill.	52	Every 7 days for about one year.	One slight symptom. Is now well.	I gave it in 5 gr. doses allowing patient to take 6 doses day before chill day, then 1 two gr. pill every day for 6 days, and repeat former dose as before. This was done for 28 days.	120 gr.	Patient was reduced physically by the long recurrence of these paroxysms so that his life had almost become a burden. His digestive powers were *markedly* compromised. He had been treated by all the Cinchona alkaloids without arrest of the paroxysms	E. Newton Campbell, M. D., Walnut Grove, Illinois.
161	W. H. male Had tried everything without success.	37	Many & constantly for six months	1	20 grains in six powders, 1 every 2 hours. Commencing after the paroxysm.	30 grs	Patient has had ague for at least six months; said he had tried almost everything—was entirely discouraged. It has been two months since the last of the *Dextro-Quinine* was taken. No return of the paroxysms and "Richard is himself again."	E. Newton Campbell, M.D., Walnut Grove, Illinois.

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MEDICAL AND SURGICAL

Journal.

VOL. XXXVIII——MARCH 20, 1880——No. 6.

Original Contributions.

ARTICLE VIII.

VESICAL AND URETHRAL CALCULI SUCCESSFULLY REMOVED BY LITHOTRITY AND MEDIAN LITHOTOMY.

By W. HUTSON FORD, M. D., of St. Louis.

CASE I.—*Lithotrity; Calculus Impacted in the Prostatic Urethra returned to the Bladder and Crushed in two sittings.*

Mr. W. M., æt. 40; married; salesman; of short stature but athletic build; temperate in all his habits. Had never suffered from gravel. His father and sister, however, had been so affected, and one of his children has had well marked brickdust deposit in its urine when only a few months old. In October, 1877, Mr. M. consulted Dr. P. G. Robinson, of this city, for some uneasy feelings in the bladder, especially pain during the last moments of micturition, and afterwards. Had never experienced anything like nephritic colic. A week or so after this he brought a calculus of the size of a small hazel nut which he had passed. The urethra was spacious. He had never had gonorrhœa. Shortly after passing the calculus, he presented himself again with a recurrence of the symptoms, this time accompanied

with almost constant uneasiness increased during micturition, and some dribbling. Dr. Robinson found a stone lodged in the prostatic urethra too large to pass, which he thrust back into the bladder. I visited the patient at Dr. Robinson's request, and sounded him for stone on the 31st of October, 1877. A single calculus was detected in the bladder. Thompson's lithotrite (fenestrated) was introduced at the same sitting, but I did not deem it advisable to crush. He was ordered some pills of blue mass, calomel and podophyllin on one or two nights, with twenty grains of quinine daily.

November 8.—Having retained his water for about two hours, Dr. P. G. Robinson kindly assisting, the patient was placed upon his back, with the hips elevated on a pillow, the lithotrite passed and the stone seized without difficulty. It measured on the shaft of the lithotrite nearly seven-eighths of an inch in the direction in which it had been seized. Three or four crushings were made, and the instrument being cleared as well as possible, was withdrawn from the bladder; but in spite of the efforts made to clear the bladder, a good deal of detritus still remained between them, and I was sensible that the urethra was scraped more than I liked during the withdrawal of the lithotrite. No anæsthetic was administered. The patient was kept rigorously in the recumbent posture until the third day, and allowed to make water only while lying on the back. He felt no annoyance during the first forty-eight hours. On the afternoon of the third day, however, he was taken with a severe rigor, followed by high fever. This was effectually combatted with quinine and veratrum viride, and he continued to do very well. On the fifth day he had another rigor with fever, the tongue became thickly coated, and he began to feel discouraged and weak. I therefore determined, in accordance with Thompson's advice under similar circumstances, not to wait for a disappearance of the symptoms, but to finish the crushing at once. I did so next day, pulverizing all the fragments I could find. He had no recurrence of the rigors, and began to amend in a day or two. Ten days afterwards he resumed his business duties.

The calculus was of uric acid, scarcely, if at all, incrusted with phosphates, and very hard, requiring sharp turns of the lithotrite to crush it. An effort was made to collect all the fragments, but much of the finer particles was lost, so that it was not possible to determine the weight of the entire stone. The

points especially observed in the treatment of the case were to forbid any attempt to pass water in the erect posture *at all*, until after the last crushing, the patient being kept recumbent for two days after each crushing, and the intervention with the lithotrite for a final crushing as soon as a disposition towards recurrence of the rigors became obvious, and cystitis began to manifest itself. In such a condition, says Thompson, it is a mistake to wait and treat the cystitis by the usual remedies, which will be useless as long as the exciting cause remains. The fragments should be at once broken up in one or two sittings, and if not passed readily by the patient, removed by Clover's suction apparatus. We would now use Bigelow's, which is really an important *development* of Clover's aspiratory tube, or operate from the first by the method lately introduced by the skillful Boston surgeon. The case detailed was by no means a difficult one. The patient was in excellent health. There was no cystitis nor cloudiness of the urine, nor any urethral or prostatic disease, and through the sagacity of his attendant physician, Dr. Robinson, the diagnosis was positively made as early as it ever can be. I have concluded to place it on record in view of the extreme rarity of lithotrity in the West, notwithstanding the claim of this mode of dealing with stone upon the resources of surgery. In a statistical publication by Andrews and Lacy, of Chicago, in 1877, issued before the date of the above operation, entitled "The Mortality of Surgical Operations in the Upper Lake States," I find the following under the caption "Lithotrity:" "This operation has been inexcusably neglected in the Lake States. I have record of only one case, which was, however, successful." Within the last two years a disposition is evident among surgeons to operate by lithotrity in appropriate cases, and this mode of dealing with stone is now so much better understood than formerly, and its true place so much more exactly defined with regard to lithotomy, that it will doubtless grow in popularity. One of the principal dangers of the operation, viz., impaction of fragments in the urethra, will become a thing of the past, if we can venture to extract all the fragments at one sitting by a suction apparatus, such as Crampton, Clover, Thompson, and Bigelow more especially, have now developed, and many surgeons are at present experimenting with. The patient whose case is above detailed, now two years after operation, remains free from

stone. He suffered a little for a few weeks after the crushing, with irritability of the bladder, but this passed off, leaving him in perfect health.

CASE II.—*Large Urethral Calculus of long standing; extraction through the perineum; another calculus removed from the bladder by Median Lithotomy on the same occasion—Internal Urethrotomy.* Mr. T. T., æt. 22, married, with children; a country merchant; tall, well developed and strong, though his face betrays signs of long continued suffering. Presented himself for a preliminary examination Sept., 18, 1879. Circumcision had been performed sometime before for a narrow preputial opening. Bulbous bougie No. 21 F. is arrested at 2½ inches down—No. 16 barely passes. The urethra is contracted beyond, but so exceedingly sensitive that it was not possible to make an examination of the deep urethra without anæsthesia. The stream of water is very small, the urine neutral in reaction, turbid, highly ammoniacal when freshly passed. Has had frequent attacks of epididymitis on one side at a time. Has never passed any blood, and has been able to ride on horseback with but little inconvenience, if any, until lately.

Defecation for a long period has been painful to him, especially when the bowels were costive. Has never had a gonorrhœa. The urethra is evidently congenitally narrow, while the external genital organs are well developed. The prostate is tender to the touch and placed higher up than usual, being also somewhat swollen.

Being engaged in business, he was unable to remain in the city more than a day or two, and was advised to return as soon as possible for a formal examination under ether, meanwhile washing out the bladder with warm water twice a day and using some anodyne suppositories. His bladder trouble had begun when he was a boy of eleven or twelve years of age and had steadily increased since then. No examination of the urethra had ever been made. Having left the city, he wrote me about a week later, that the bladder washings gave him great pain, and that he was suffering much more than when I saw him. I directed him to come back to St. Louis as soon as his affairs allowed, as it was necessary to make a thorough diagnosis of his case before I could advise him further.

About Oct. 3d he returned to the city, and spent a few days visiting places of attraction and transacting business, moving

about much more than was usual with him. Having called on him on Oct. 5th, I found that he was suffering from an epididymitis of the left side, which rapidly grew worse, requiring active treatment. A diagnostic exploration was therefore postponed until twelve days later.

Oct. 18th, 3 P M.—Ether having been administered, Drs. A. A. Rowland, N. B. Carson and Rubey assisting, the results obtained were as follows: The meatus barely admits No. 21. F. Two and three quarter inches down there is an annular structure No 16; an attempt to pass the same or a smaller instrument was unsuccessful.

Thompson's searcher could not be passed, nor could the bladder be reached with a small conical sound. The left forefinger in the rectum encountered a hard, roundish, and somewhat nodulated tumor lying in the mesial line anterior to the urethra, about an inch in thickness and just under the internal fibres of the sphincter ani. This tumor was scarcely movable, and a portion of the membranous urethra and the apex of the prostate could be easily felt beyond it.

The tip of a bulbous bougie could be made to pass between the tumor and the finger in the rectum, and the point of Thompson's searcher could be made to pass to a certain distance, but was so strongly deflected laterally by the mass, to the patient's right, that no entrance could be gained or was attempted, into the bladder. Both instruments produced an unmistakable grating sensation, and sound of rubbing audible to the bystanders. A large urethral calculus lay encysted in and near the lower portion of the membranous urethra. Of course it was not possible to proceed further, or at least was not deemed advisable to attempt to enter the bladder with the sound or otherwise, as any search for a stone possibly lying there could be readly instituted during an operation for extracting the urethral calculus.

The manipulations caused no particular annoyances at the time, but a day or two afterwards the epididymitis showed symptoms of recurrence. He was treated with alkaline diluents and warmth to the hypogastrium, with elevation of the scrotum, anodynes etc., and as the affection did not show any disposition to disappear altogether, I judged it best not to wait, but proceeded four days later to extract the calculus by a perineal section, having also made full preparation in all particulars for median lithotomy which not improbably might be found necessary.

October 22, 1 P. M.—Present, Drs. Rubey, Y. H. Bond, N. B. Carson, A. A. Rowland and L. M. Kennett. Etherization having been effected by Dr. Kennett, and the patient tied up as for lithotomy, the perineum having been shaved, a small staff grooved on its convexity, was passed as far as it would go between the stone and the finger in the rectum, and securely held in this position by Dr. Bond. An incision in the median line of the perineum beginning about a quarter of an inch from the anal margin, and extending two inches upward, was now made through the superficial structures. The finger being in the rectum, a sharp pointed bistoury with its edge directed upwards was entered at the inferior angle of the wound, and passed directly backwards, under the stone, until its point engaged in the groove of the staff. The deep structures were then divided upwards in correspondence with the superficial cut. The staff being withdrawn, the rounded end of the stone could be felt at a depth of about an inch and a half, but it could not be seized without considerable difficulty on account of its smoothness, the roundness of the presenting surface, and the fact that it was closely enveloped by the condensed sac in which it lay. The knife was used once or twice to divide the sac upwards, and when grasped by forceps the stone proved adherent to its bed, and could not be drawn out. It was therefore crushed with forceps *in situ*, and extracted piecemeal. Part of it was brought away with the scoop, and most of it detached from the sac-wall, not without much trouble, with the finger-nail. There was but moderate bleeding. Thompson's searcher was now passed into the bladder directly through the wound, and a stone was detected lying on the right side of the bladder. The impact of the instrument was perfectly audible to the bystanders. A little manipulation with the sound showed that the stone was not a small one, probably an inch or rather more in its shortest diameter. The forefinger was therefore passed into the bladder and its neck stretched as thoroughly as possible. Blizzard's knife was next passed on the groove of Little's staff, and the prostate and neck of the bladder very moderately incised in a horizontal direction on the left side. The curved forceps grasped the stone in a very favorable direction at once, and extraction presented no difficulties until the portion of the membranous urethra just bordering on the excavation in which the urethral stone had lain, was reached. The walls of the urethra in this place were so dense and inelastic that the progress of the stone

was temporarily arrested, until an incision had been made directly downwards, the finger being in the rectum, with a probe-pointed bistoury. The calculus was then withdrawn unbroken without further trouble. The entire fixed urethra and neck of the bladder was now dilated with Weiss' three-bladed screw dilator to three-quarters of an inch, and Gross' regurgitant nozzle passed into the bladder, which was freely washed out with warm water. No fragment of stone could now be detected by the finger, introduced through the wound. Otis' dilating urethrotome was next passed down to the perineal cut with its knife concealed, screwed up to 25, and the contracted portions and strictures of the perineal urethra as well as the meatus divided; the instrument was next screwed up to 31, F, and the knife withdrawn entirely at that guage, the meatus being incised as the whole instrument was withdrawn. Blunt steel sound No. 31 was now passed without any hindrance into the bladder.

Probably half a pint of blood was lost during the whole operation. The extraction of each stone was necessarily somewhat tedious, owing to the anomalous condition of the parts. The calculi proved to be what is termed "alternating," composed of alternated layers of uric acid and phosphates. The bladder stone measured very nearly an inch in thickness by an inch and a quarter in length, and weighed, when moist, 160 grains. The urethral calculus weighed 185 grains.

The patient recovered very well from the anæsthesia. There was some oozing from the wound for the first twenty-four hours. The bowels were kept confined by opiates, the pulse ranging between 76 and 100 for several days after the operation. On the 26th, bulbous bougie No. 31 was passed down to the perineal cut. He was allowed some raw oysters on the 27th and 28th. At the latter date the bowels were still confined and urine was passed about equally by the wound and by the penis. Control of micturition was regained on the 26th. On this day a little bleeding occurred from the meatus but was promptly arrested.

October 29th, bowels not yet moved; bulbous bougie 29 passed as far as the perineal end; pulse and temperature normal; appetite good; no further bleeding.

October 30th, better; bulbous bougie 31 passed to perineum; bowels opened by an enema, quinine as heretofore, grs. v, thrice daily.

The further history of the case is as follows: the epididymitis

which existed in a sub-acute form at the time of operation gradually disappeared. The wound closed finally on the sixteenth day. He had an intercurrent derangement of the liver, and a rigor which did not recur. After the tenth day conical sound No. 31, followed by a blunt sound of same calibre, was passed, at first every third day, and during the third week every fourth day. The urine became perfectly clear and free from odor. The vesical irritability gradually declined, and about November 16 he was obliged to get up but twice at night to make water. He left the city for his residence in the country on November 28, twenty-eight days after the operation, looking nearly well and passing a full sized stream of urine, but there was some disposition towards overflow, in consequence of the diminished size of the bladder. This has gradually disappeared and he now passes his sound once a week. Towards the end of January he wrote me that he was quite well, had resumed his business and felt like a new man, in fact, "that there was no trouble in sight."

In this case all that was necessary was done at once by three distinct operations, viz: the perineal section and extraction of the urethral calculus, the extraction of the vesical calculus by median lithotomy, and free internal urethrotomy. Nevertheless, the recovery of the patient was very prompt under the circumstances and quite uncomplicated, save by the disposition towards rigors, which yielded to abstinence and appropriate remedies without difficulty.

The case is a remarkable one, in view of the very long sojourn of the urethral calculus in the membranous urethra and the activity and fecundity of the patient meanwhile. Impaction of a calculus in the deep urethra is common enough in childhood, but is far rarer in adults. Erichsen speaks of having removed an extra-urethra calculus, weighing an ounce, from a patient who had suffered for many years from tight stricture. He also alludes to a remarkable instance of this kind, where the pathological specimens are preserved in Sir R. Carswell's collection at University College. Holmes speaks of urethral calculus as a common cause of retention in boys, and states that "it is affirmed," that calculus has occasionally been *formed* in a pouch behind a stricture of the urethra. I am informed by Dr. Wesseler, of this city, that he removed a urethral calculus from an adult by perineal section a year or two since, but there was no stone in the bladder.

Reports on the Recent Progress of Medicine.

OBSTETRICS.

By Walter Coles, M. D., Collaborator for the Journal.

The Proper Time to tie the Umbilical Cord.—The time when it is best to ligature the cord after the birth of the child—whether late or early—has been the subject of much interesting controversy since the question was raised and discussed by Dr. Budin, in *Le Progres Medicale*, 1875-6, with the result of investing the question with a practical importance hitherto little appreciated. The data upon which these various arguments rest, seem for the most part reasonable and reliable. Budin contends that by tying the cord immediately after the child is born, *i. e.*, before it cries out lustily, and all pulsation has ceased, the infant is deprived of about three ounces of blood, which properly belongs to it.

The observations of Schücking (*Berlin Klin Wochenschrift*, 1877) supported the same view. He considers it consistent with physiological law that nearly the whole quantity of blood contained in the fœtal portion of the placenta is finally transferred to the infant. This author differs with Budin, however, in accounting for such transference through suction due to the respiratory movements of the child, but refers it to pressure exerted by uterine contractions on the undelivered placenta. Hence, he argues, that when the placenta is suddenly expelled with the child, or from any cause, such as *post-partum* hemorrhage, it has to be removed immediately. We should afterwards expel the fœtal blood from its vessels by pressure with the hands, before applying the ligature.

Schücking estimates the amount of this "*reserve blood*," as he calls it, at from 70 to 150 grammes, and the time requisite for the transfer, varies from a few to several minutes, being determined by the amount of pressure exerted by the uterus on the placenta. Contrary to the general practice in this country, he protests most strongly against treating asphyxia of the newly-born by allowing some hemorrhage to take place from the cord. This treat-

ment is founded on the supposition that the child's heart is already too full of blood, of which it must be relieved at any price—an idea which he thinks is quite erroneous. For at the first effort the child makes at inspiration the blood rushes into the thorax, leaving the extra thoracic vessels empty. These are filled by the "reserve blood," from the placenta; but if we tie the cord quickly and thus cut off this supply of "reserve blood," while at the same time we allow some blood to escape from the fœtal end of the cord, we increase the anæmia, and, as a natural consequence, lessen the reflex sensibility of the medulla. As a direct consequence of this, the intervals between each effort at inspiration become longer, till finally the breathing stops altogether.

Prof. Zweifel,[1] of Erlangen, has instituted a number of experiments with a view of determining the exact amount of this so-called "reserve blood." He found that the average quantity of blood remaining behind in the placenta when the cord was tied immediately after the child was born was 192 grammes; but when the cord was not ligated till after the placenta had been pressed off by the hand, the average amount of blood contained in the placenta was only 92.29 grammes, thus leaving a large surplus of blood in the placenta, which is capable of being physiologically introduced into the child's circulation, and which, he contends, is essential to its well-being. For it is well known that all children for some days after birth lose weight (amounting on the average to 220 grammes), but the amount of such loss was found to be only 156 grammes when the ligature was not applied until after the expulsion of the placenta.

The observations and experiments of Meyer, of Copenhagen, agree with those of Zweifel in the main, *i. e.*, he concludes that the infant gets the benefit of more blood when the cord is tied late, but finds the actual amount is much less than the latter supposes— not sufficient, he thinks, to exert any material influence, other things being equal, on the future welfare of the child. These views are substantially concurred in by Dr. Max Weiner. Dr. Hofmier, of Berlin,[2] also started out with the view of disproving Zweifel's statement, but after a number of very carefully conducted experiments, arrived at facts which strongly corrobo-

1. Centralblat f. Gynækologie.
2. Centralblatt Gnækologie. 1878. p. 409.

rate them. Before commencing his investigations, Hofmier held that Zweifel's conclusions were necessarily erroneous, since the amount of blood claimed to be lost to the child, by premature ligature of the cord, (before expulsion of the placenta) was too large (100 grammes), while in the average infant the amount of blood, when the cord was tied as is customary, amounts to only 175 grammes. He performed thirty-two experiments, placing the child, the moment it was born, and before the cord was tied, on delicate scales to note its weight then, and also the change in weight after some minutes had elapsed. The result was an average increase in weight of 63.6 grammes, or about 2 ozs. This increase in weight he considers due to the extra amount of blood that has during the interval entered the fœtal circulation from the placenta. After a number of weighings, Hofmier fully concurs with Zweifel that children whose cords are ligated early lose more weight after birth, and commence to pick up flesh later than those in which the cord is not ligated until after the expulsion of the afterbirth. A fact which he attributes to the fuller blood-reserve enjoyed by the latter class.

Dr. A. Ribemont, in the *Annales de Gynekologie*, for February, 1879, sums up his conclusions on this subject as follows:

1. By ligaturing the cord late the infantile circulation receives on an average an addition of 92 grammes of blood (Budin).

2. This blood which is contained in the placental vessels is most necessary for the full establishment of the infantile circulation.

3. The blood is drawn into the infantile circulation, chiefly by the suction power exerted by the expansion of the chest walls (Budin), the pressure exerted by the uterus on the placenta (Schücking, Porak) having no considerable effect.

4. In case of asphyxia where the child has a bluish hue, the cord ought not to be immediately tied, nor should any hemorrhage be permitted from its fœtal extremity.

5. Ligaturing the cord late does not expose the child to the smallest immediate or ulterior danger.

6. The infant is thereby placed in the most advantagous circumstance possible for its development; it loses less weight, and regains what it has lost both sooner and quicker than if the ligature be made immediately.

7. The expulsion of the placenta is thereby rendered easier

and there is less resistance offered to its escaping through the cervix. (Budin, Schücking.)

8. It is therefore most important that the cord should not be tied until all pulsation in it has entirely ceased.

On the contrary, Dr. Parak, [3] whilst admitting that the child receives more blood by delay in tying the cord, argues that this extra blood is a disadvantage rather than otherwise. For he holds that such children are much subject to infantile jaundice, and to the various effects of plethora, such as hemorrhage from the stomach, bowels and vagina and he adduces cases in support of this idea. — (Condensed from Dublin Journal of Med. Sci., June, 1879.)

Translations.

FROM THE FRENCH.

EXCERPTS FROM LATE FRENCH JOURNALS. [Translated for the JOURNAL.] By A. H. OHMANN-DUMESNIL, M.D., of St. Louis.

SPONTANEOUS CONTRACTION OF UNSTRIATED MUSCULAR FIBRES IN THE LUNGS AFTER DEATH—M. Hénœgue, in a communication on this subject to the Biological Society, gave an account of experiments made by him and Brown-Séquard. The conclusions to which he arrives are as follows:

1st. The state of expansion, of dilatation or of collapse, the relative volume of the air vesicles of the different lobules or of different groups of lobules become modified after death.

2d. These modifications may be merely transitory, cease and then become apparent again at various points, having limited areas; they are produced slowly and leave the lung in a final state of expansion, which permits of a knowledge of the site, extent and degree of vesicular expansion, dilatation or collapse even after complete dessication of the lungs.

3d. These modifications are due to contractions of unstriated

3. Revue Mens. de Méd. et de Chir. May and June, 1878.

muscles contained in the parenchyma of the lung and in the bronchia and represent in the lungs the peristaltic contractions observed in other viscera.

4th. This interpretation is based upon the very conditions by which these modifications of vesicular expansion are produced. In fact, the pulmonary elasticity has effected the whole action of retraction. These changes are produced slowly, progressively with arrests now and then, and augment under the influence of irritants such as cold, carbonic acid, pinching, etc., and greatly resemble the peristaltic movements of adominal viscera.—*Gazette des Hôpitaux*, Jan. 8, 1880.

BRAINS OF CRIMINALS—M. Hanot presented to a society in Paris four brains, derived from the post-mortem examinations of as many criminals. Prof. Benedikt, of Vienna, recently called attention to the structure of the brain in certain criminals; he has observed the presence of four frontal convolutions in twelve assassins condemned to death. M. Hanot has found the same anomaly four times in eleven autopsies. The subjects are not criminals of the worst type but thieves of long standing and regular "jail-birds." In the brains presented the second frontal convolution seemed to be doubled, the supernumerary one being situated at this point. This is especially the more curious, as not a single case of the kind has been observed in patients dying at the hospitals not criminal.—*Progrès Médical*, Jan. 3, 1880.

SPECIAL SPOTS OBSERVED ON WORKERS IN GOLD—At the National Medical Association of Lyons M. Clément made a communication on this subject. These spots, he observes, may occur on any part of the body; they are confluent on the anterior aspect of the forearm. They are caused by pricks from gold-wire. They are brown in color, not projecting, irregularly elliptical, their smaller extremity directed downwards, being separated by healthy skin. These may be mistaken for powder burns or for the spots seen on grindstone cutters. In the former case the spots are darker and more grouped together, in the latter they are of an earthy appearance and the foreign body can be easily extracted with a needle.—*Lyons Médical*, Jan. 4, 1880.

MALIGNANT PUSTULE—Dr. Dumolard, who has devoted some attention to this subject, gives the following table of differentia-

tion between the non-infecting and the infecting form of malignant pustule, together with the natural course pursued by each:

NON-INFECTING.

1st week. This pustule begins in a point and enlarges with a vesicular areola, and around it the skin is tumefied and of a more or less dark red color.

On the fifth or sixth day there is an œdematous swelling around the pustule and on a part of the affected limb. On this œdema, whose proportions are always moderate, there are never any disseminated vesicles. The skin remains warm and of a heightened color; it is never distended like the infecting pustule.

Whilst this tumefaction is going on, there is generally some fever with cephalalagia and diminution of appetite, but the patient is never prostrated like in the infecting postule.

2d week. The swelling of the part and the fever disappear at the end of two or three days; the appetite returns to disappear no more. The eschar less hard and dry than in the infecting pustule, enlarged and extends at the expense of the vesicular areola, which finally disappears.

During the whole of the first week the eschar was but a few millimetres in diameter; now it is two, three or even four mm. in extent.

3d and 4th week. The evolution of the disease is complete, repair will soon commence and these two weeks will be sufficient to eliminate the gangrenous parts.

The eschar, which is never deeper than the skin, has its greatest thickness towards the center, which is the last point to detach itself.

5th week. This last week is generally sufficient for the complete cicatrization of the wound, and the cicatrix, superficial and not considerable, never interferes with the motions.

INFECTING.

1st week. This pustule originates and developes with a vesicular areola, and the skin about it is white and discolored.

On the fifth day, and sometimes earlier, an indurated œdema comes on, distending the affected limb and rapidly reaching the trunk. This swelling is not limited, it is much more extensive than in non-infecting pustule. The skin is white, cold and smooth and always has several disseminated vesicles or bulbœ.

At the same time that these local phenomena manifest themselves, general symptoms of infection declare themselves, supervenes at the end of the first week or during the first days of the second week.

However, reaction is sometimes observed even at the time that the general symptoms seem well advanced. This salutary process is the result of a spontaneous effort of nature, but it is more often due to the therapeutic measures employed in the shape of energetic cauterizations.

In these cases the damage done is considerable and the suffering long and terrible.

Secondary eschars are formed and bring about gangrene of the skin and cellular tissue to a very great extent. After a long time the eschars separate, cicatrization proceeds slowly and almost always the cicatrices prevent the free play of the muscles and articulations of the affected limb.

It may be said that the malignant infecting pustule terminates generally in rapid death, and when the patient resists the general infection he loses the use of the limbs affected by the pustule, on account of the depth to which the destructive process attains.

—*Lyon Médical* Jan. 11, 1880.

FROM THE SPANISH.

A. H. OHMANN-DUMESNIL, M. D, Translator. [For the JOURNAL.]

INFLUENCE OF MALARIA ON VISION.—In connection with this, Dr. Emilis Naranjo relates the following: D. Aniceto del Sol; born in Madrid, æt. 35, of a good constitution, a merchant in Matanzas, consulted me in the month of October last. He had, at that time, the following symptoms: a slight yellow tinge of the face, supra-orbital cephalalgia, aggravated by nocturnal exacerbations, internal hyperæmia of the conjunctiva, photophobia with

dryness in both eyes, saying that he had no lachrymation. He furthermore had pertinaceous insomnia, nausea and some vomiting, epigastric sensitiveness and constipation. Temperature 39.5° C. (103.1° F.) and pulse, 120.

The patient related that he had, some three months previously, been fishing on the banks of the San Juan; that he had been suddenly seized with a violent chill lasting from midday till evening, accompanied with headache and general lassitude. He then had chills and fever for a considerable time, and acting on the advice of his friends took various remedies which seemingly benefitted him. This, however, was followed by a swelling of the inferior extremities, which disappeared after an abundant diuresis. The fever again appeared, and, with this second attack, came on the symptoms detailed above. Never had any disease previously except measles and rheumatism, having always been in good health. He furthermore stated that the pain in his eyes (photophobia) was so intense that he had to keep them closed, and endeavored to remedy this by the use of collyria of acetate of lead and rose water, and finding no relief in this, applied to the author.

Recognizing the cause of this, without any hesitation, as malaria, an emeto-cathartic was immediately prescribed, to be followed by sulphate of quinia, 1.25 grms., to be taken daily for several days. In less than 48 hours the supra-orbital pain became less intense, the photophobia also diminishing. A collyrium composed of borax, 0.4 grm., laurel cherry water, 2 grms., and distilled water, 60 grms., was ordered, together with frictions over the superciliary region with belladonna ointment and tonics with iron to combat the anæmia consecutive to malaria. The patient was furthermore given general hygienic directions in regard to habitation, etc. The recovery was rapid and complete. The infiltration in the lower extremities was a consequence, no doubt, of the state of the blood affected by malaria.—*Cronica Medico-Quirurgica de la Habana*, Jan., 1880.

Proceedings of Medical Societies.

ST. LOUIS MEDICAL SOCIETY.

SATURDAY, FEBRUARY 14, 1880.

A Case of Rupture of the Uterus.

DR. T. F. PREWITT.—I will report a case. On the evening of the 12th a physician informed me that he had a bad case of labor, and he expected it would be necessary to perform craniotomy; he wished me to see it with him.

I came to the house and found the woman greatly exhausted, the pulse feeble, and on examination I found the labia as large as my fist, and all the genitals greatly swollen. I found an extraordinary condition of the abdomen, which I was unable, at first, to account for. The uterus seemed to be in two; the upper portion seemed to have tilted forward as though it was a tumor, directly proceeding from the spinal column, and then there was a depression. I could feel the fontanel, but could not determine the exact position. The head was pretty well down. The woman had been in charge of an old midwife for twenty-four hours nearly, and the physician who called me had seen her on the afternoon of that day. She had been in labor all the night before. He found a very bad condition of things, and thought he would need some assistance. The woman, as I said, was greatly exhausted, and this condition I was unable to account for. It looked as if we had two tumors, two uteri—certainly a very extraordinary condition of things. While the head was still down, not pressing on the perineum, I applied the forceps, delivered the head, and found very great difficulty in doing anything with the shoulders; in fact, the left shoulder, which was down, did not seem to dip into the pelvis at all. I succeeded in getting a blunt hook in the left axilla, and pulled with a good deal of force, and finally pulled the arm out. There was considerable retraction of the head, and I did not succeed seemingly in moving the body a particle. I had the woman moved still further toward the edge of the bed. I told the doctor there was a tumor or something that interfered with the passage of the body. After getting fillets over the head, I made traction

Editorial Notes.

Bromidia.

"After a thorough and continued trial of Battle & Co.'s "Bromidia" at St. Vincent's Asylum, I can cheerfully certify to its great therapeutic value and purity. Its effects are much more rapid and efficient than the ordinary chloral mixtures. The sisters in charge of the ward, after using the Bromidia and comparing its effects with the ordinary chloral mixtures used so long as a hypnotic, claim great superiority for the former. Its success has been attested where the other in similar doses has failed. The purity of Schering's Chloral and the extracts of cannabis indica and Hyoscyamus which it contains, together with the small dose of the remedy which is required, make it almost invaluable to medical practitioners, who are guaranteed a pure and efficacious remedy in the use of "Bromidia." They are not left at the mercy of Pharmacists who sometimes dispense inferior if not adulterated preparations of Chloral. We could not for some time be induced to try the remedy, entertaining some prejudice against all such preparations. But experience in it use requires us as a matter of justice most emphatically to endorse the preparation after an extended and impartial trial. In fact we expect in furture to use "Bromidia" exclusively.

J. K. Baudry, M. D.,
Physician St. Vincent's Asylum."

We have used Battle & Co.'s preperation called "Bromidia" for over one year. We are so well pleased with its effects that we expect to continue to prescribe it in many cases in which we formerly used chloral. It is especially beneficial for patients having troublesome coughs from pharyngo-nasal ulceration.

To The Readers of the Journal.

On the 25th of last month, I addressed you a circular, which stated that the price of the Journal would be $4.00 after the 25th of March. As some of the subscribers may not have received this notification, I will extend the time to the 25th of April next. The following are the reasons for this advance in the subscription price, as stated in the circular:

The recent great advance in the price of paper (nearly 100 per cent.), as well as of everything connected with the publication of the Journal, compels me, much against my will, to increase the subscription price from $3.00 to $4.00 per annum. This increase of the annual rate will not take place until the 25th of April, 1880. Those who have paid or will pay $3.00 previous to that time, will get the Journal for the year 1880.

I would be pleased if you would call the attention of physicians of

your acquaintance, who are not subscribers to the Journal, to this contemplated increase of the subscription rate, and to the offer to give the Journal, during the next 35 days, at the old price.

As the Journal is *larger than any $4.00* medical periodical in the United States by *sixteen pages*, I might make it smaller and thus decrease the cost of publication, but the demand by contributors and by Medical Societies for space is so great that I dare not.

The Journal being the official organ of the St. Louis Medical Society, the Tri-State Medical Society, the American Laryngological Association and the Southern Illinois Medical Association, it will publish their papers with the discussions following each. These discussions were taken at length, for the Journal, by its own stenographic reporter, and will pass through the Committee of Publication of each society. In this way the reader has placed before him subjects of more than ordinary importance, prepared with a view to criticism, thoroughly discussed by quite a number of experienced observers. In other words, it is the views, given at length, of one who has thorougly studied his subject.

No other medical periodical in this country gives its readers so much carefully prepared matter, or the views of so many prominent men on the subjects given. Hoping for your favorable response, I am yours, with kind regards,

Thos. F. Rumbold.

March 20, 1880.

The North American Review for April has for its leading article a paper entitled "McClellan's Last Service to the Republic," which covers the whole period of McClellan's military career, from the flank movement to the James to the battle of Antietam. It is intended to vindicate the General against the charge that he was over cautious and unnecessarily slow in his movements, and contains many statements of an interesting character. Sir Francis Hincks contributes a paper on the "Relations of Canada with the United States." The author's principal object is to show that the recently enacted Canadian Tariff is not an act of retaliation against the United States for their refusal to establish reciprocal free trade between the two countries in products that are natural to both. Canada, he says, is desirous of renewing the reciprocity treaty, and is ready to concede all reasonable demands. The Rev. David Swing writes about "The Failure of the Southern Pulpit." According to him, the Southern Pulpit is without influence on public opinion in the South, whereas it might be, and ought to be, a great engine for the moral and material regeneration of the people. Charles Stewart Parnell sets forth the reforms in the laws of land tenure which are advocated by himself and his political associates, under the heading "The Irish Land Question." The Book Notices are by Mr. Edward Cary.

For sale by booksellers and newsdealers generally.

in the direction of the perineum, and eventually succeeded in drawing the body out. Finding the placenta did not come, I passed my hand into the vagina, and observed what I thought at first was a tumor in the interior wall of the uterus. It seemed to me greatly thickened. This was the fifth labor of this patient. The others had gone on without great difficulty, and had been attended by midwives. It was a large child. I passed in my hand and removed the placenta, detached it, without being able to appreciate the condition at first. I examined carefully and satisfied myself there was rupture of the uterus in the posterior left side; the cervix at least was ruptured; whether it extended into the peritoneum I did not examine to satisfy myself; I thought I would be doing more mischief than good. The wall of the uterus after tearing was thrown to the front, and the thick wall of the uterus was what mislead me at the outset in supposing it was a tumor. There was no uterine wall behind; it was thrown forward. When I delivered the head and shoulders there was a complete revolution of the head; (at first the face presented to the left side;) on delivery it turned completely over. It was evidently the result of the laceration of the cervix which caused the child's body to turn in the exit. In this case the position was evidently the result of a want of antagonism between the anterior and posterior walls of the uterus. After the laceration, the upper portion of the womb tilted forward. There was to a certain extent flexion of the uterus, the result of want of antagonism. The woman seemed cheerful; her pulse was quick and feeble; the child of course was dead. The woman had a horrible looking prospect before her; I took it for granted she would die. I think in this case the laceration was the result of protracted labor with a large child.

The midwife said the others were not so large; I think it would have weighed twelve pounds. There was very little hemorrhage.

In reply to President Maughs, Dr. Prewitt said the uterus contracted quite firmly, but tilted forward.

Dr. G. Hurt asked if the projection was right above the symphysis pubis or in the region of the umbilicus.

Dr. Prewitt — Rather more in the region of the umbilicus. I think the difficulty of drawing out the shoulders was due to the fact that the thickened wall of the uterus was between the shoul-

der and the symphysis; the lacerated uterus spread out; turned forward; the thickened œdematous walls of the cervix were between the shoulders of the child and the arch of the pubes.

DR. HURT — I hope the Doctor will watch this case, and give us the results at some future meeting. The representation of the diagram suggested to me the possibility of rupture, not of the uterus so much as the muscles in the abdominal wall, allowing the uterus to give way for want of support in the interior surface, and form a kind of hernia. Whether this would occur without a hernia of the intestine at the same time I do not know.

DR. ATWOOD—In connection with the report just read by Dr. Prewitt I will detail the history of two cases of a similar character. In the year 1866, I was called to see a woman who had been for many hours in severe labor under the care of a midwife, who informed me that two hours preceding my arrival and when the pain was most violent there was a sudden and complete cessation of labor, immediately followed by hemorrhage. Upon examination the os was found dilated and dilatable, and passing my hand into the uterine cavity I discovered the feet of the child therein, while its body protruded through a rent in the uterine wall traversing the cervix and lower segment. The patient presented all the phenomena characterizing extreme physical shock and I had already administered brandy and ergot. Grasping the uterus through the abdominal parietes and manipulating to secure uterine contraction I extracted the child, and fixing a compress with a tightly drawn bandage over the lower abdomen, instituted treatment in the further management of a most hopeless case. This consisted in the administration of stimulants, tonics and full diet. Soon there was established incontinence of urine and fæces, with a most offensive sanious discharge per vaginam. The latter was met by frequent injections of dilute Labaraque's liquid of chloride soda. The woman continued to improve in spite of most disagreeable surroundings and soon made a complete recovery.

In an interview with her husband I cautioned him against impregnating his wife, informing him that if again in labor she would die before he could bring a physician. The statement was based upon the known fact that cicatricial will rupture easily and sooner than normal tissue and under uterine action the cicatrix at the site of the injury would be torn open and a fatal result

ensue. The family moved from the vicinity and for two years I heard nothing of the further history of the case. At the end of that time I encountered the husband who informed me that his wife had again become pregnant and when taken in labor he had started for assistance, when, within twenty steps of his door he was called back and found his wife dead.

In another case I saw my patient upon the day following the commencement of labor. Its outset was vigorous and its cessation immediate. A steady straining effort simulating rectal tenesmus, substituted uterine pains. There was great physical shock. Stimulants with ergot were freely administered. Vaginal examination disclosed a patulous os with seemingly the membranes presenting. Upon pressing my finger upward I detected a forward movement of the supposed membranes which, upon further descent, proved to be a loop of intestine. The patient shortly died and the following day an autopsy was made, when, as was anticipated, I found the uterus filled to distention with intestines, its lateral wall ruptured from cervix to fundus and the fœtus in its membranous envelope well up towards the diaphragm.

A Menstruating Virgin Uterus.

Dr. C. E. Briggs exhibited as a pathological specimen a menstruating virgin uterus, and said: This specimen comes from a case which presented many features of interest. I expect to give a report hereafter. At present I wish to show the specimen in as fresh a condition as possible. I do not wish to make a full report, but begin at my first knowledge of the case. On the 9th of this month I was called at about 2 o'clock in the morning to a case said to be one of great exigency. I found a young woman, some nineteen years old, sitting up in bed, struggling for breath, evidently in a great deal of distress and spitting blood, not profusely, but aerated serum, rather strongly tinged with blood. It was represented to me as an old case of phthisis pulmonalis. I looked at it and concluded after some time that the active hemorrhage had stopped. Notwithstanding that appeared to be the state of the case, the young woman suffered much dyspnœa and was exceedingly pallid, and though her pulse would not be called a bad pulse, yet there was some serious difficulty. So I gave a guarded prognosis. I inquired how the hemorrhage commenced. She had been dancing quite violently. They told me she fell over while dancing. That was in the afternoon, I

think. About nightfall she began to have her menstrual discharge and I understood it was the regular time she should have it. That, of course, excited no surprise, but afterwards she was observed to put her handkerchief to her mouth and remove blood. The case was a complicated one; she had had what was called vicarious menstruation. I do not know that ever before she was known to have the menstrual discharge and spitting of blood at the same time. The discharge of blood from the mouth began to be excessive, and finally, not to go into all the details of the case, I may say that at 10 o'clock on the morning of the 10th, about twenty-four hours afterwards, she quietly died. The trouble apparently commenced at the heart. The difficulty surrounding the diagnosis led me to make a post-mortem examination. Connected with the post-mortem was another advantage, a very great one. Here was a healthy young woman who died suddenly in menstruation. Therefore we had an unusual opportunity of securing what we supposed to be a healthy menstruating womb, and that is the point I will bring forward tonight. The womb presented other peculiarities, but there is no need to dwell on them. The specimen, having been taken promptly, was a very beautiful one. I took it on the 10th, quite shortly after death, and we found the phenomenon of menstruation very nicely presented indeed, with all the vivid coloring that marked the outlines of the membrane of the uterus, showing its swelling and demarcation. In looking at the ovary we found recent corpora lutei; also the Graafian vesicle recently ruptured. That, too, was an extremely beautiful thing. The clot was of a dark color, and all the tissues were nicely marked out. The Graafian follicle measured half an inch in its longest diameter. It is a pity we lose some of the beauty of the specimen by the procedure necessary for examination. I invited some gentlemen to be present. Dr. Engelmann, I understand, has had it drawn and colored, and that drawing will represent more truly the state of the case than this. In the specimen the yellow has gone almost entirely, and the fresh coloring has been changed. We can scarcely make out where the old corpora lutei were. Gentlemen will be able to see where the congested mucous membrane is, lining the body of the womb, whence comes the menstrual flow; also be able to see the ruptured Graafian follicle, and also the abnormal form of the os. If desirable, there are other points of slighter moment—the

shape of the womb, as presenting a marked interior flexion.

Dr. Wesseler asked the speaker to state to what he attributed the cause of death.

Dr. Briggs — I intend to report the case. I think it would not be well to go far into that part of the case; it is so complicated. What I think was the cause of death was the general oozing of blood into the vesicles of the lungs, and that the lungs were drowned out—suffocated—and there was a condition of the heart that favored such a state of things.

Dr. Engelmann — We are deeply indebted to Dr. Briggs for preserving and bringing this beautiful specimen here, not only beautiful but a most instructive and most valuable one. It of course is not as distinct now as when it was fresh; the colors are not as well marked, yet it will show distinctly to every one several mooted points. There are two points which this specimen proves distinctly and clearly, points which are under discussion. The first is that in menstruation the entire mucous membrane is not shed; the second that there is a temporal relation between ovulation and menstruation; it may not be on a certain day, but within the early days of the menstrual flow. With regard to the first point, I think that it is generally accepted on the continent of Europe, and this country, that during menstruation it is only the superficial layer of the mucous membrane which passes off with the menstrual discharge, perhaps only the epithelial cells lining the cavity. Williams, of London, maintained in an article published in '75, in the *British Obstet. Journal*, that the entire mucous membrane is shed at every menstrual period. That theory has found a great many adherents in England, and is entertained by the more prominent English authorities. We have a specimen here that shows distinctly that the menstrual flow goes on, and the hypertrophied mucous membrane remains in the womb, and is not shed. We have here the fresh ruptured follicles. It is hardly to be called a corpus luteum; there has not been sufficient time for the formation of the yellow ring. We have the follicle filled with coagulated blood, for the center of that mass is blood, as shown by microscopic examination. There is another point which the specimen beautifully shows, and that is the thickening of the mucous membrane of the body of the womb. The cervical lining is in its normal condition, unaffected by menstrual congestion but the mucous membrane of the uterine cavity proper

is very much hypertrophied; it forms that soft bed in which, if conception takes place, the ovum is engrafted and finds shelter for its growth. There is an increase of thickness in the mucous membrane during menstrual congestion. You see that the glands are comparatively straight. These glands become much more tortuous and enlarged in the menstruating uterus, and the thickening begins before the menstrual flow; during the last days of the menstrual flow it gradually subsides; perhaps the last layer of hypertrophied tissue passes off with the menstrual flow, and in the first days after the cessation of the menstrual flow, shrinking takes place, again to bud out with the next menstruation, and prepare the bed for the reception of the impregnated ovum.

DR. A. C. BERNAYS said that he did not think Dr. Engelmann was justified in saying that the specimen proves that menstruation and ovulation fall together. He thought the coagulation in the Graafian follicle was eight or ten days old, and was inclined to think that the thickening of the mucous membrane of the womb was caused by the ovum falling in the womb; did not think that the mucous membrane was thick when the egg got there. The microscope, he was pretty sure, would show that there was some organization going on at the periphery of that clot. In regard to the casting off of the whole mucous membrane, he agreed with Dr. Engelmann in that respect.

There was a practical point in regard to the time when the coitus would be most likely to produce pregnancy. Until the year 1873 it was held that the most likely time for pregnancy to take place was just after menstruation. It was supposed that during menstruation the egg was thrown into the cavity of the womb, and was there ready to receive the spermatozoa. It had been found to be entirely different. Dr. Engelmann had proved, or came near proving, that ovulation coincides with menstruation, and if that was the case, the most likely time would be when coition takes place during menstruation. Another factor came in here, that the spermatozoa will live in the womb for at least eight days, or as long as eight days. Though there may be no coition for eight days, there may be spermatozoa in the womb, ready to fertilize the egg when it comes. So that according to these facts it made no difference; it was entirely immaterial at what time coition took place, whether during men-

struation, or before or after; fertilization was equally probable at all times.

President Maughs spoke at some length on the theory of the menstrual act, and explained some of its conditions. In regard to the time of conception, he said most women conceive five or six days after menstruation, and yet some women are so liable to conception they would conceive at any period. He knew a woman who had children very readily. She did not want to have any more. She was advised by her family physician only to have connection with her husband in the middle of the menstrual period. She observed the direction carefully, only to conceive as promptly as before. We have no difficulty in accounting for that. The ovum remained and was liable to fecundation for eight or ten days, or even longer, after.

Saturday, February 21st.

Dr. Wm. Porter — The case I have to report will probably furnish a pathological specimen: The case is one that I am sorry to say found its way into one of our daily papers of recent issue, and I have been requested by some members of the Society to make a brief statement about it, especially as it is supposed that the operation was a failure, which is not true. The patient, a young woman of some twenty-seven or twenty-eight years, was sent to me for examination a week or ten days since, by Dr. Louis Bauer.

I found her suffering from great dyspnœa. A large tumor occupied the greater part of the space below the vocal cords. The history was, that for some three if not more months, the patient had some trouble in the throat, a little difficulty of breathing, some difficulty in speaking, and a little pain. Three weeks before, her breathing became very much embarrassed and her voice was almost entirely gone. The tumor as it appeared under the laryngoscopic light was large, very firm when touched by the probe, and so smooth in outline that I doubted the character of the tumor. I thought it might have been one of the ordinary polypi, but pressure of the probe showed it was firm, and the surrounding tissues were much involved. The involvement

of the laryngeal tissues resulted in a loss of motion, and the left vocal cord was held almost in the median line. At the examination, I expressed my fear that this was malignant. Surgical interference was advised.

Tracheotomy was performed at the College of Physicians and Surgeons to-day, by Dr. Bauer. When the larynx was laid open, the cricoid cartilage was cut. As expected, the whole laryngeal tissues of the left side were involved.

The tumor was hard, deep-seated and left no doubt as to its character. The tube was left *in situ*, and it may be, though I do not know what Dr. Bauer's intention is, that further operative interference may be pursued. As yet there is no ulceration; as to the ultimate result of the case provided the tumor is not removed, there can be no doubt.

Operations for Harelip.

DR. ED. BORCK—Mr. President, I have here some diagrams. The first is intended to represent a double harelip, with cleft palate. I do not introduce this case because harelip, or the operation therefor, is something extraordinary, but because every operation, no matter how trifling, has some points of interest, and will teach us something. I saw this child when it was but a few weeks old; it looked ghastly—ugly. The nostril was perfect; the right intended lip had hardly any lip at all, and of course no external formation of nostril. There was a little pear-shaped pedicle attached to the gums, in the middle line, containing the rudiments of two front incisor teeth.

I was at first tempted to cut it off, but I only gave it a twist, and in a few days nature separated it. I had strong adhesive strips applied from right to left, and from left to right, to draw the parts together. I also instructed the mother to apply pressure. In this way the parts were brought more in apposition. When the child was about three months old I operated, first upon the right side. The dotted lines show the incision. I separated, thoroughly and completely, the cheek from the maxilla, keeping the knife close to the bone. I then divided the whole nasal wing; this leaving me a triangular flap. I then made this cut; next peeled the edge from the middle piece, not dividing the frenum superioris, and united both flaps by hair-pin sutures. I had some hemorrhage. To check this the needle is the best instrument. Sloughing followed. The wound sepa-

rated, except a small bridge. I introduced a large needle; it healed nicely. A month later I operated on the other side, which was not so difficult. I used harelip sutures. It sloughed. Again a long needle was put in it, and it healed by suppuration. The result, I think, is beautiful. You can hardly see any cicatrices. The object in these operations is to obtain union by first intention, and to get it we should wait until the bleeding has completely stopped, and the wound is clear of all clots before the sutures are put in; but if hemorrhage is severe, the needles and ligature will control it best.

I had another case of double harelip, and without cleft palate. Both nostrils were well formed. I operated in this manner: Instead of cutting or peeling the edges off completely, and then uniting, I introduced a small knife about a line from the lower edge of the lip, carrying my knife around to within a line of the other side of the fissure, then pulling it down and uniting by needle sutures. This left a nipple on one side, but none on the other. I cut the nipple off, so as to equalize the two sides; union by first intention followed. This method of paring all the tissue and pulling it down, instead of cutting the edges completely, is not new. Nèleton has done and recommended that, but he cuts the mucous membrane through, separating it, while I do not divide it at all. The advantage gained is this: If union by first intention does not take place, a natural bridge will be left, and it will hold both ends together. I have used the needle sutures—generally fine sewing needles—and the ligature. I also tried glass pearls, as suggested by Dr. Prince, of Jacksonville, Ill. Wax pearls answer better and can be broken more easily, but corriander seed answers the purpose very well. I use two or three on each side. They hold firmly, and if swelling takes place you can easily break one or two to make room, without much disturbance to the parts.

Dr. Bernays described and illustrated at some length on the blackboard his method of operating for harelip, by which he claimed more perfect results than by the old method, since, he claimed, that it left less deformity and a more natural facial expression.

Fractures of the Forearm.

Dr. T. F. Prewitt presented a boy who had suffered a fracture of both bones of the forearm nine weeks before. The Doctor did not see the case until seven weeks after the accident,

when he found that the bones had united at a very ugly angle. On refracturing the bones for the purpose of correcting the deformity, he found that the ulna was longer than the radius; the latter forming a string to the bow, as it were. This difficulty had been gradually overcome by means of a rubber bandage, which through constant pressure, assisted by a simple splint, had brought about parallelism between the bones and a very satisfactory result.

SATURDAY, FEBRUARY 28TH.

Compound Dislocation of the Wrist.

DR. ED. BORCK — I will introduce to you to-night a very interesting and rare case, which will demonstrate what conservative surgery may accomplish with the assistance of the beautiful workings of nature.

This boy, now present, is Fred. Lenrin, aged 13 years. On the 11th day of October last, he went about two miles out of town to hunt and pick up persimmons. He was so unfortunate as to fall from a tree, injuring his left wrist joint badly. When I saw him I found a complicated dislocation of the carpal bones, scaphoid and semilunar, upon the posterior side of the radius. The head of the bone was subcutaneous anteriorly, the ulna protruding through the skin also anteriorly, and exposed about two inches in front of the carpal bones and skin, cleanly stripped of all its attachments, but there was no fracture. We must remember that this part of the ulna is very subcutaneous and that it does not enter into the articulation of the wrist-joint proper; that it is separated by the triangular fibro-cartilage.

The lower epiphysis of the ulna, as well as of the radius, does not become joined until about the twentieth year; here, however, the bones seem to be well and prematurely developed. There was some hemorrhage. In this condition the lad walked all the way home. Chloroform being then administered by my assistant, Dr. Charles H. Foster, I kept the arm flexed at right angle, grasping the hand with my right hand, and making extension, pushing back, or rather keeping in their places the long bones with my left hand.

It was not very easy to accomplish the reduction. However, by introducing a strong dull probe, I succeeded in pushing back the skin over the protruding part of the ulna. Then bending

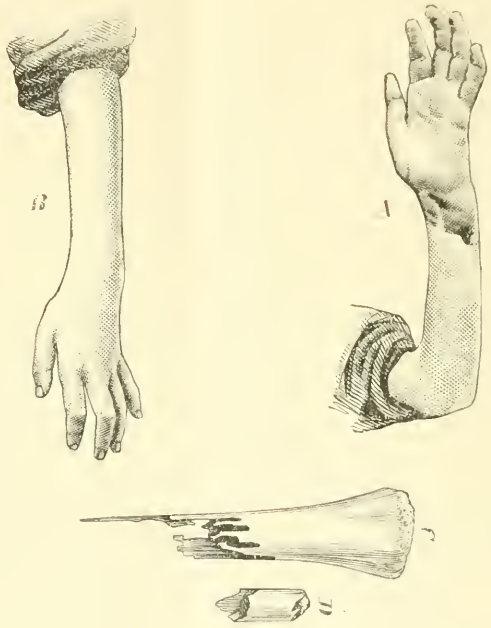

Fig. 9.

A, Anterior View (showing wounds).
B, Posterior View.
C, Head of Radius (half size).
D, Piece of Ulna (half size).
[Engraving by W. Mackwitz, after photograph by B. F. Reynolds.]

the probe, I felt for the supinator longus, which is attached to the styloid process of the radius. It was separated from it. The head of that bone protruded between its tendon and the tendon of the flexor carpi radialis, and the flexor below.

I continued my extension, and by a little manipulation, pushing the tendons one side with the probe, I accomplished the reduction. The boy had no feeling in the thumb, index and middle fingers. They were cold and he could not move them, an evidence that the median nerve was injured. He suffered but little pain. The wound was washed and dressed with carbolized water, a compress and bandage applied and the arm put upon a straight splint. Everything went well for the first three or four days.

Here I may remark that during the whole treatment the boy suffered but little pain, and this is a point worth noticing, one which I have observed in many cases, that whenever there is but little or no pain after a severe injury like a compound comminuted fracture or dislocation, there is generally trouble ahead. So in this case. The boy, being of a puny constitution, never was a hearty eater, but of a tranquil disposition. He became feverish, the wound assumed an ugly type, and an attack of erysipelas set in. Some tendons sloughed, and after the erysipelas had disappeared, the head of the radius became necrosed. You can always tell necrosed bone by its peculiar smell.

For sometime the arm did not make any progress either way. Nature gradually pushed the bone through the wound, and now the question arose, what to do, resect, or to leave nature to have its own way. The latter was adopted—to wait till the bone was ready to come out, and then we would remove it.

About the sixth week after the injury, I removed the head of the radius with a pair of strong forceps. This was comparatively easy under chloroform. The arm was then placed in a pasteboard splint, with a fenestra cut for the wound, and kept at perfect rest. The wound healed rapidly.

Another attack of erysipelas set in, abscess formed near the elbow, and it was opened in due time. Then a wound on the ulnar side appeared, and again the smell of the necrosed bone was perceived. While nature's repairing process continued on the radial side, nicely filling up the vacant space made, destruction proceeded on the ulnar side. About four months after the injury, I removed about an inch of the ulna. Nature had forced

it out and while so doing had repaired the injury, having united the bone completely, resulting in a perfectly solid bone. I here show to you the specimen. The treatment was a liberal diet, milk, eggs. soup, etc.; quinine to control the fever and as a tonic iodide potassium, 25 centigram doses every three hours during the attack of erysipelas. I consider the iodide potassium a most valuable remedy to control traumatic erysipelas; externally warm water dressing.

I do not need to speak of the process of repair. You all understand how nature accomplishes that. The boy looks better than ever he did; he has gained flesh, and will have a good and useful arm. You observe he can move his wrist; extension and flexion is almost perfect; supination and pronation to some extent.

[The Doctor then undressed the arm for the inspection of members, and a recess was taken. He expressed a hope that he might present the youth to the society one year hence, so that further improvement might be noted.]

DR. ATWOOD—In connection with the case reported by Dr. Borck, I have a remarkable occurrence to report. Over a week ago a boy about twelve years of age, living fifteen or sixteen miles from the city, received a gun-shot wound, losing two and one-half inches of the radius and ulna. The cartilage was exposed; the cutaneous structure above and below the wound was intact; the wound was on the lateral aspect. Thinking to save the hand I removed all the spiculæ of bone, and after washing out the wound, I dressed it on a straight splint, and applied warmth to establish circulation. Two or three days after, it became evident there was no circulation in the hand. I proceeded to amputate. At the time of amputation there was no arterial hemorrhage. After amputation there was venous oozing. I thought the arteries would show themselves in the flaps, but they did not, neither was there any hemorrhage. After waiting half an hour, and being unable to find the several vessels, I simply closed the wound in the usual manner, and up to this time, some eight or ten days having elapsed, there has been no hemorrhage. The wound is healed by first intention.

DR. POLLAK — Which part did you amputate?

DR. ATWOOD — The forearm; the middle third.

DR. F. J. LUTZ — I do not think it should be laid down as a

rule that we should trust to nature to close large arteries, or that they should be left to look after themselves; yet the following incident came under my notice. About three years ago I had occasion to amputate a hand in consequence of a crushing which the member received by a heavy piston being driven down into a cylinder in a stove-pipe manufactory. The wrist joint was laid open. I attempted for thirty-six hours to save the hand by artificial warmth. It became necessary to amputate. I performed amputation with the assistance of Drs. Gregory and Wesseler. Pressure on the brachial artery was omitted, and there was no blood. Considerable search did not detect the artery, nor was I able to find it. Subsequently, by making pressure on the forearm, Dr. Gregory succeeded in squeezing out a blood clot which had closed up the ulna artery. I suppose if I had not found the severed end of the artery, it would have closed without bad results, for the plug was very firm. I should not, however, trust to nature alone, for secondary hemorrhage might come on, and our patient fare badly.

Dr. A. C. Bernays— There is a method of managing amputated stumps which I can recommend highly. It involves the question of using ligatures on wounded arteries. On the middle third of the leg and the forearm, I have repeatedly, after removing the limb, sewed up the wound in order to close the wound and bandaged it with Esmarch's bandage. I performed amputation, ligated no artery and put on the bandage. Sometimes you will find oozing of blood through the interstices of your bandage, but I have rarely seen that, if the bandage is tightly applied. It is my practice not to remove the dressing for six or eight days, at the end of which time the flaps will gradually be found united.

In operations below the middle third of the forearm and leg I think this procedure is safe. The arteries after being cut retract, and the pressure of the bandage causes coagulation. If there is hemorrhage of the branches, it gets between the flaps and coagulates, unless fever sets in. I have found it an excellent way to treat stumps. It seems rather risky, but I have not seen any evil results from it. One case I call to mind. A man shot himself through the forearm. After amputation, after removing the rubber bandage the stump was closed by sutures, enveloped in absorbent cotton, and a tight bandage applied. At

the tenth day union had taken place, and the sutures, I found, could be removed. Of course there were no ligatures to be taken off. The case could be dismissed from the hospital at once.

SOUTHERN ILLINOIS MEDICAL ASSOCIATION.

ADHERENT PLACENTA. By H. V. FERRELL, M. D., of Carterville, Illinois.

Many years ago Dr. Dewees said that adherent placentas were generally heard of in the practice of young and inexperienced physicians. Perhaps there is not a member of this society of much experience who has not been called time and again by some young practitioner to deliver what he gravely informs him is an adherent placenta, but which is in fact simply retained and that too in the majority of cases by the vagina.

A few years ago I was called in great haste by a young graduate in medicine to deliver what he thought was an adherent placenta. On making a vaginal examination my finger came in contact, just within the vulva, with a soft movable substance which I took to be a clot, but on turning it out found it to be a wad of cotton about the size of a hen's egg. In my surprise I asked the doctor how it came there. He told me that it was a tampon saturated with a solution of persulphate of iron and placed there to restrain the hemorrhage. The placenta was found in the vagina, just above his tampon.

Less than a year ago I was sent for by a "ten-yearling" to see a woman who had been confined at two o'clock in the afternoon. The doctor gave her some composition tea and went home; before going, however, in answer to the inquiries of the old women about the afterbirth, he told them that he would come down in the morning and attend to that, but that if he did not, it would make no difference, for it would rot and come away as it often did in cows. The old dames were not comforted much by this assurance and in the night had the doctor called back. He administered more composition tea, told them that it was "growed," advised them to send for me and went to bed. I was aroused by the husband late in the night. He told me what

was wanted. I asked if his wife was comfortable, he said she was; if she was flooding, he said she was not. The night was bad, the roads were bad and so was the pay, and I didn't want to go, so, with that professional charity which should characterize us all, I sent him to a very intelligent young physician, recently located in my neighborhood, with word that if he found anything wrong to send for me and I would assist him. On arriving, Dr. H. found the patient and the "ten yearling" both comfortable, the placenta lying loose in the vagina, and would have dropped out if she had got on the vessel. On the way back Dr. H. remarked: "Why, Doctor, that placenta was detached." "Of course it was," says the ten-yearling, "if it hadn't been *de*tached I could have got it away."

Such cases as these have brought the subject of adherent placent into disrepute and cause the profession to look with distrust upon cases of this kind and a physician is perhaps to be regarded as unfortunate who has a case to report. The authorities very generally, universally, so far as I know, admit that there is such a thing as "adherent placenta" requiring the intervention of art for its delivery or even defying art and maintaining its adhesion. From conversation with physicians one would be led to suppose that this is an extremely rare occurrence, not one of the many that I have ever talked with upon the subject, old veterans in the profession, do I remember ever to have heard admit that he had ever found a placenta that he could not deliver. They peel it off, scratch it off, tear it off, get it off in some way. There is a feeling in our profession that it is ignominious to let a woman die undelivered, and I believe the same feeling exists against an undelivered placenta. Far be it from me to question the veracity of a physician, yet I must confess to a very strong suspicion that the fear of this ignominy may have prevented cases of adherent placenta from ever seeing the light. A few years ago I delivered a placenta from a woman eleven days after her confinement. She was attended by two physicians, who, so far as I know, have never reported that they had found a placenta which they could not deliver.

It is not my purpose in this short paper to enter into the causation, morbid anatomy, literature or statistics of the subject. I will merely say that in 541 labors I have met with two undoubted cases of adherent placenta. One partial, the other complete. In March, 1870, I was called to see a woman who had

been recently delivered of her tenth child. I reached her about 4 o'clock in the morning and she had been confined under the care of a midwife, about sundown the evening before. Soon after the birth of the child she began to flood and continued to do so until my arrival, when I found her pulseless, fainting, vision almost gone; in fact, in articulo mortis. Hastening to make an examination I found the uterus inert and about one-half the placenta detached; the other seemingly firmly adherent. Whether I could have torn off the detached portion or could have detached the adherent portion I do not know. My first endeavor was to produce contractions of the uterus by means of stimulants, ergot, handfulls of snow and vinegar carried into the uterus, etc., but to no purpose. My patient was dead in a few minutes. No remedy should be judged by its effects in a patient so far gone as this. One word as to the placenta. It seems to me that it would only have been hastening the fatal termination to deliver or to attempt to deliver it before the contractility of the uterus was restored. As before stated, this was her tenth confinement. Beginning with a girl, every other child was a boy, and with each of them there had been trouble in delivering the placenta. With the one before this, the afterbirth, as they said, had to be taken from her by a doctor.

In August last I was called in consultation to a case requiring instrumental delivery. After the child was delivered, we found a completely adherent placenta. It was attached to the anterior wall of the uterus, and extended almost to the os internum. With the hand in the uterine cavity, carrying it over the entire inner surface, to be sure that there was no hourglass contraction, the whole margin of the placenta could be explored. Ergot was freely given, the uterus contracted so firmly as to have led to the impression, from external examination alone, that the placenta had been expelled. Crede's method by expression was faithfully and perseveringly tried; pulling upon the cord, the uterine tumor could be brought low into the pelvis, letting the cord suddenly loose the tumor would instantly rebound to its former position. No hemorrhage. What was to be done? After long continued, fruitless efforts by the ordinary means, it was finally determined to undertake to peel it off by insinuating the fingers between the placenta and the uterus. This was faithfully tried, but no progress whatever was made. I could not even get it started. What next? I either had to abandon all further at-

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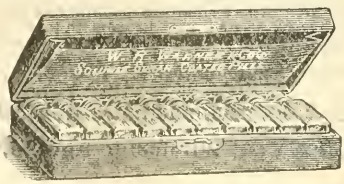

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tempts, or leave it to nature. At this point I confess that my fear of the ignominy before alluded to, had some weight with me. I now decided to undertake its removal by the tearing up, scratching off process. It makes me shudder to think of it—it ought never to be mentioned but to be condemned. Before proceeding, however, we prepared for hemorrhage. Taking the largest sized Barnes' dilator from my obstetric case, I filled it with a solution of sub-sulphate of iron, and had it ready for use. Then introducing my whole hand into the uterus, I endeavored to tear the placenta up, and bring it away piecemeal. I succeeded in getting away as much perhaps as a single handful, when the profuse hemorrhage, which had already made its impress upon the patient, warned me to desist. Taking now the end of the tube of the dilator in my hand, and carrying it directly into the torn up substance of the placenta, my assistant, by squeezing the bulb forced the Monsel solution upon the bleeding surface, arresting it in a few moments.

It was now found that it was impossible to deliver that placenta without immediate death of the patient, and we were compelled to leave it. Before doing so, I thought I would break the cord near its attachment to the placenta, but I found upon trial that I could not do that, and had to, or did, cut it with the scissors. The only object in doing so was merely the looks of the thing. By means of warmth, stimulants, etc., we soon succeeded in bringing about such a degree of reaction as to enable us to feel the pulse at the wrist, and in a few hours we had the satisfaction of leaving our patient in reasonable comfort. This was Sunday morning, just after daybreak. Friday following, the placenta was found detached, and was delivered without any trouble. The woman got along without a bad symptom until she was able to sit up and walk about, when three weeks afterwards she was exposed to a rainstorm, took pneumonia, and died in a few days. Hereafter when I meet with a placenta that I cannot deliver by what we may term the ordinary means, I shall leave it to nature, which, as in this case, does in a few days what, with all our skill, we cannot accomplish. It seems to me that by leaving it intact the patient is less exposed to hemorrhage or to septicæmia, than if we leave it in a torn up, shreddy condition. I am sure that if I had not taken the precaution to prepare the Monsel solution beforehand, the patient would have died before it could have been prepared.

Translations.

FROM THE ITALIAN.

STORIA COMPENDIATA DELLA CHIRURGIA ITALIANA. DAL SUO PRINCIPIO FINO AL SECOLA XIX. Del Professore CARLO BURCI.* [For the JOURNAL.] JOSEPH WORKMAN, M. D., Toronto, Canada, Translator.

COMPENDIATED HISTORY OF ITALIAN SURGERY—CONTINUED.

Down to the beginning of the 12th century, surgery had not been disjoined from medicine, or regarded as a distinct and essentially separate art; for though it was practically so, because the physician could not embrace the whole range of the healing art, and was therefore obliged to divide the work, this was not done under any legal provision. Whoever treated the sick by virtue of his legitimate ministry, might do so in any form of disease. But the history of medicine has clearly shown the necessity, and even the utility of specialists for the cure of certain affections, and these practitioners did not always belong to the medical caste. They were often empirics, that is uneducated in their art; masters, not doctors; ignorant of general diseases, and frequently mere traders or charlatans. Italy certainly had these, by some of whom she was honored; as the Brancas in autoplasty, and the Norcini in Lithotomy. Every people have had, now have, and always will have, in even the brightest times, their popular practitioners, who, vaunting their fame-borne secrets, have treated, and will, regardless of prohibiting laws, continue to treat both poor and rich. It will be impossible ever absolutely to restrain either human credulity or human knavery; and what law could ever compel a sick man to be treated only by an authorized physician? The law may punish a quack, but for every one punished a hundred will go unpunished, and the rogues will always gain in the confidence of the credulous. What then? Will the majesty of science be thereby stained? Will the honorable physician, who is expert in his art, and noble in its exercise, ever lose his

*Published in the proceedings of the Royal Institute of Superior Studies, Medical and Surgical Section, Florence, 1876.

rank, or that dignity which society concedes to him? Has not medicine its specialties, and does not surgery show them to us, represented by men worthy of all praise?

Medico-chirurgical practice, at the beginning of the 12th century, though modest and not yet raised to fame by celebrated men, was generally in the hands of the priests, monks, and conventual laics. There were neither diplomas, nor authorities to grant them; the studies pursued, and the caste to which the person belonged, gave authority to practice, but to the high ecclesiastic dignitaries, such a vocation, although pious and charitable, soon appeared as too likely to lead astray the clergy, and withdraw them from their proper duties, and to loose the regulars from obedience to their superiors; and it might besides be a temptation to their avarice; it therefore appeared that the practice, but especially that of surgery, was an immodest profession, and that as the church abhored befoulment of the hands with blood, this was a manifest injury to chastity and sacerdotal purity. It was for these considerations that in the Lateran Council of 1139, it was, with threats of grave penalties, prohibited to the clergy of every order, to teach or practice the healing art. The Councils of Montpelier in 1162, of Tours in 1163, and again of Montpelier in 1195, confirmed this prohibition. In that of Tours, afterwards, the ecclesiastics were absolutely forbidden to practice surgery, as that was regarded as soiling worst the white and immaculate veil of the temple.

In the 12th century, therefore, surgery was, by the Councils and Popes, banished from the sanctuary, and medicine was, at the same time, forbidden to them, as if the art of healing were a thing dishonorable to the altar. But it is not a little marvelous that the Papal Bull, by which the Pontifex created the medical faculty of Montpelier, in the 13th century, ordered that the teachers and scholars should *be clerics, and wear the tonsure*, and consequently belong to, and in a certain measure depend on the ecclesiastical authority, and obey the canonical laws. In fact the masters wore the priestly garb, obeyed the clergy, and must remain unmarried. It certainly was no small injury to surgery to be then abandoned by those who had practiced it with devotion, and under some protection. It now had to take refuge among the ruleless and popular operators—the barbers and men of mean repute — who, by their ignorance, cöoperated in aggravating that decadence so much deplored by Albucasis. It had now becom

an art despised by medical philosophers, who disdained the healing of disease by operations of the hand. The school of Salerno, alone, in the 12th and 13th centuries, maintained the unity of teaching, and to it we owe that surgery was preserved in some degree of decency. The Arabian and the Jewish surgeons, who had been instructed in the Eastern schools, and who now traveled over Europe operating and reaping abundantly from the doctrines learned by them there, had now a prosperous time. Had all been as able as Albucasis, surgery would have stood indebted to the Arabians for its revival, and for those principles which conducted it afterwards to its new grandeur.

But God had prepared for the world, and more especially for Italy, which had suffered so much from the barbarians, and from head to foot had been devastated and ruined, new splendors and new triumphs. In the two centuries preceding the 13th, the *Comunes* sprang to liberty; the small states formed themselves into a Republic; the language was created, and it was polished and softened in songs of love; the Crusades made Italy the center of commerce; the Greek and Latin philosophy, sustained by Bœtius, St. Augustine and St. Thomas, recommenced to see the light, and contended against the Arabian abstrusities and pernicious philosophies; universities were created by the Princes, and by Papal Bulls, and the Popes took care of them; they appeared in Bologna, Naples, Pisa, Padua and Pavia, etc.; the school of Salerno, *antiqua mater et domus studii*, flourished, and taught the healing art, in the footprints of Hippocrates and Galen; reason and justice resumed their empire over force and proud power. In this Italian resurgence, which afterwards became diffused through all Europe, and carried light and liberty over the earth, the surgeons also gathered their palms of glory and became masters.

After the clerical period to which I have alluded, and after the *veto* imposed by the councils on the ecclesiastics practicing medicine and especially surgery, many clerics still continued to practice, and from having been abbots of monasteries became chief physicians to Kings, (*e. g.* Fra Domenico of Pescara, and Fabrizio,) and Constantino Africano Monaco was made the Grand Master of Salerno; surgery became *quasi* laical, and as such it arose in Italy with the new birth of sciences, arts and letters. Just as in the days of Hippocrates, there were the Periodenti (or itinerants,) so there was no scarcity of specialists in every branch of

surgery in Italy. The Norcini and the Preciani were noted as lithotomists and oculists, who, in the 13th Century, had *from time immemorial*, earned fame from their operations for stone, the cure of hernias, and diseases of the eyes. Afterwards there arose masters of the arts, who rendered Italy and France celebrated. "*It is* (says Dezeimeris,) *to the Italians that the revival of Surgery in France must be ascribed. Italy had to lead the way to the other countries of Europe, in the career of scientific progress.*"

Two schools in the 13th Century, rivaled each other in the teaching of surgery in Italy, that of Salerno, the *ancient mother*, which had at its head Constantino Monaco, called Africano, and the other, that of Bologna, instituted by Ugo da Lucca, where human anatony was taught by Mondino and medicine by that talented Florentine Taddeo Alderotti.

Ugo da Lucca was a physician at Ferrara, in the pay of that Dukedom; he went in the Crusades to the Holy Land; he came back, and taught surgery at Bologna, where he died old, in 1258. He had a school and pupils; he wrote little, but taught wisely. Teodorico, his son and scholar, bishop of Bitonto and Cervia, and confessor to Pope Innocent IV, practiced surgery successfully in Bologna, and wrote a book on the art, 1266, in which he followed the doctrines of his father and other famous masters. There followed Ugo, in the same school, Ruggeo da Parma, a man of rare genius, who, having completed his studies in Salerno, returned to Bologna to teach about the middle of the 13th century. He wrote two treatises on practice, one very little, and another larger (in folio, Bergamo 1498); he also wrote, *De modis mittendi sanguinem de cujusque utilitate.* His books became the law and the texts in Italy for a long time. They were annotated by his disciple Rolando, in his work, *Libellus de chirurgia* and in the work of Rolando, by four masters of Salerno.

Among the able surgeons who appeared in Italy in the 13th century, renown was acquired by Bruno da Longobucco, who practiced the art before Theodoric, and wrote at Padua his *Chirurgia Magna* (1252). He knew and quoted the Greek and Italian instructions. For the cure of fistula in ano he wisely recommended the method of incision. Those first surgeons of the renaissance, and many others who succeded them were Arabists who as they did not know the doctrines of Hippocrates or Galen, were moulded in practice by the works and precepts of Albucasis and thus the Arabic doctrines entered into the very blood of

Italian physicians, out of which a very long time for its purgation was required, on the way back to classic Greek medicine.

Surgery, however, in this age, had two men whose names and works, history will ever record with honor. These were *Guilielmo da Saliceto* and *Lanfranco*. Guilielmo Placentio, native of Saliceto, was the most learned surgeon in the art, and the best instructed of his time, the one who merited the greatest fame, both for his works and his practice, and because he wrote *that which he saw*, thus exhibiting the fruit of his own experience and his own operations and cures. He studied at Bologna, following the precepts of Taddeo and Mondino, and of Del Bono who there taught surgery. He had, as companion, Bertruccio, Mondino's dissector, who was afterwards master to Guido di Chauliac. He was born, it is said, in 1210; he was a learned physician and cleric; he wrote some works on medicine, and a classic treatise on surgery in 1275. After having been established in Placenza, he went to Verona, where he died in 1277. Guilielmo opened human dead bodies, wrote important histories of the diseases of men and women, and treated largely and with much ability, of wounds. A disciple and friend of Guilielmo was *Lanfranco Da Milano*, who also was a learned physician and cleric, whose life was afflicted and glorious; to him is due the honor of having carried Italian surgery into France, at a time when the precepts and aphorisms of the school of Salerno had sole dominion there. Nourished by the teachings of the chief physicians and surgeons of Bologna, and a scholar of Da Saliceto, he practiced however ably in Milan, which was then divided by factions, and he was banished by Matteo Visconti. He went into exile, first in Lyons, where he lectured on surgery; then he moved to Paris, where the art was as much in decay as theology was in bloom. On invitation of the Dean of the Faculty of Medicine, he here taught surgery publicly, with greater applause than any man could draw from private teaching. He became an associate of the college of surgeons, and had the chief part in the revival, or if it please so to say in the *birth* of surgery in France. He composed his *Chirurgia Magna et parva* (1296), which went through several editions.

He died at Paris at the end of the 13th, or in the beginning of the 14th Century. He was well acquainted with the medical schools, and instructed in every improvement in surgery. In his *Chirurgia Magna*, which contains an abundance of facts, doctrines,

and wise precepts, all arranged with much discernment, at § 243 D. we read these words, which should ever remain impressed on the mind of every one who consecrates himself to the healing art: "It is necessary to know that no one can become a good physician without the knowledge of surgical operations, nor can any surgeon have worth if he is ignorant of medicine. He must understand both."

After these great masters, Italian surgery, which after its revival had followed the wise instructions of the Greek and Roman schools, fell somwhat from its splendor, but appeared to flourish in France, where Lanfranco had introduced it.

The author here introduces the names of fifteen teachers, whose failure to avert decay of the art he seems reluctant to divulge. In all probability these *nomi autorevoli* were somewhat like the Mantuan apothecary's "beggarly account of empty boxes," and but for filling in purposes, they might better have been permitted to remain in limbo? He, however, offers the following rather lame apology for their ill success.

"Two causes at that time obstructed and arrested, in part, that progress which the earlier masters had initiated; the first was the supremacy which the Arabic doctrines, then in vogue, arrogated. These were but little calculated, in themselves, to give freedom to reason, and the physicians and surgeons above named (to-wit, the fifteen empty boxes), clung to them with warm love; the second cause was the passion for astrology, and afterwards for alchemy which infatuated the minds of the cultivators of the healing art, and often led them into wild fancies. Among these fanatics were Pietro d'Abano, Amaldo da Villanova and Raimondo Lullo. But even in this period, which included the 14th and 15th centuries, the teachings of the great surgeons of the 13th, Ruggiero Guglielmo and Lanfranceo, were not forgotten; whoever practiced the art was a physician, and, as such, also a cleric, nor did they who practiced, believe that in doing so they soiled the doctoral or the ecclesiastic garb. In this relation very eloquent are the words of Haller, in allusion to this long period: "In Italia, scientiarum matre, nunquam Chirurgia se abdicarunt. Et XII acculo et XIV, et demum XV, et XVI sæculo professores medici Academiæ Bononinensis, Patavinae, aliarium in Italia illustrium scholarum, et *manu* curaverunt et consilio, et inter istos viros summi chirurgi existerunt." Surgery, by good fortune, never fell into that abandonment and despisal in Italy

into which it was led in France in the centuries of which I have spoken, having never been in our country as it was there, turned over into the hands of barbers and bathers."

(Here follows another long list of exhumed celebrities, the rescuing of whose names from oblivion, savors more of pious patriotism than of historic discretion, and we cannot withhold our thanks to the author for the following winding up of the progress of surgery during the 15th century.)

"That which I can assert is that the Italian surgeons, in these ages, in which Arabism and Astrology had a fruitful field, and Alchemy saw the light, never ceased to keep alive the sacred fire of knowledge, which they diffused into other regions; and embracing the whole range of the art, they omitted not to occupy themselves in obstetrics and the diseases of women, and especially to follow up that malady, old or new, as it might be, which at the close of the 15th century, under the reproachful ephithet of *Syphilis*, made so much havoc in Italy. The first writers on this disease were Niccola Leonineano (1497), Coreadino Ghilino (1498), Sebastiano Aquilano (1498), Giacomo Cataneo (1499), and Giorgio Valla, of Brescia."

In the 15th century there were besides the master surgeons, especially in Italy, empirics and itinerant operators, who, not having gone out from the university schools, but having been educated in their own families, in some branch of surgery, and having from their success acquired celebrity, performed operations which the doctors did not understand. First among these were the Branca family, of Catania, in Sicily, who were restorers of noses and other soft parts, and originators of the methods and important processes of autoplasty. To these ran all who, having traveled, or fought, among the Infidels, had been so unfortunate as to lose the soft part of the nose,—a disfigurement which those barbarous countries inflicted on prisoners of war or other captives. Antonio Branca, the son of the chief empiric, restored, also, the lips and ears, and was the founder of that method afterwards vaunted by Tagliacozzi, of Bologna, of refitting the soft nose from the skin of the arm. This restorative art, which some allege to have originated in India, and of which Celsus makes mention, passed from the Branca family to the Baldasarre, and from them to those of Vianeo, and the Fojani, of Calabria, Flaminio Crasso, when Tagliacozzi made it common in Bologna, taught it, and confirmed it by his own operations.

In the mediæval period and almost throughout the fifteenth century surgery in Germany, Spain and Portugal showed some glimpses of that light which shone over Italy and France, but they were so feeble as not to merit record. The works known were few, or of small size, and they remained in manuscript. I cite, in Germany only, the *Iconographia Anatomica*, of Peiligk and Kundt, and the *Treatise of Surgery*, by Saler, published at Brunswick. In these countries a blind devotion to Arabism and fanatical superstitions, but in Germany especially that ill-founded boasting haughtiness of the sapient physicians, sometimes clerics, and always ferocious despisers of surgical operations, which were therefore abandoned to an obedient, ignorant and servile class, had great influence in preventing the advancement of surgical art. The togated or ecclesiastical physician, from the abyss of his wisdom ordered, and the manual laiic operated, and kept silence.

In the end of the fifteenth century Europe came into rich fortunes, and occupied a field on which to restore her studies, and to found those of her future schools. These fortunes were the invention of printing, the discovery of America and of lost and unknown manuscripts. Tomasso di Saleano, who afterwards, under the title of Nicolas V, died in the chair of St. Peter, found a copy of Celsus and several of other Greek and Roman authors of the times of the lesser Greeks. The study of Greek was then (1393) rendered familiar in Italy by Crisolara, but especially in Florence by Marcilio Ficino, through whom, when printing was introduced by Magonza into Italy, and, as it were, found refuge here, the most classic books of Greek literature and philosophy were given to the light, and the works of Hippocrates reappeared. Celsus was printed first in Florence in 1478, and afterwards several editions were issued in Milan and Venice. After Celsus came speedily the works of Aristotle, Galen and other distinguished physicians of antiquity. Medical studies were re-born. In the schools the authority of the Arabs diminished as much as that of Hippocrates, Celsus and Galen increased. Græco-Roman medicine resumed her empire, gave to men of the art her instructions and was restored in riches and splendor in the short space of half a century. By the aid of printing the works of the most sovereign geniuses of antiquity came back to light.

TRI-STATE MEDICAL SOCIETY.

[Reported for the JOURNAL.]

MILK-SICKNESS; ITS MICROSCOPY. By J. GARDNER, M. D., of Bedford, Ind.

In August of the present year there occurred in the southwest part of Lawrence county, Ind., several cases of milk-sickness, two of which were fatal. Though not in the active practice of medicine, I took a lively interest in the disease because of its obscure and unsettled pathology. The most of you know how unsatisfactory is the literature on this disease and how uncertain are any of the conclusions that have been reached by authors.

Feeling that the true cause or causes of the disease could only be discovered by abandoning the beaten track and making a new departure, I did so, with what degree of success I leave you to judge after you have heard the results.

Perhaps, before going further, a brief synopsis of the leading and generally constant symptoms will be in order. There is always nausea. This may be constant or it may be intermittent and paroxysmal. Where constant, the smallest quantity of either fluids or solids taken into the stomach produces retching, and vomiting until the stomach becomes wholly empty, when it ceases until the stomach receives something to make the nausea again become active vomiting. In the intermittent form the paroxysms are usually about an hour apart, and in the intervals between, the nausea is absent and the patient comparatively easy. There are always more or less eructations of an offensive gas. The odor of the body and of the breath are of a peculiarly offensive character, and are in themselves sufficient in most cases for founding a diagnosis. The respiration is of that slow and sighing character, described as "*tired*." The pulse is usually small and sometimes frequent, though this not always so. This, with the full and frequently labored action of the heart, is another peculiarity of the disease. The heart throbs and labors and beats against the thoracic walls with as much energy as in the worst case of hypertrophy and valvular insufficiency at the time the radical artery may show but a weak and thready pulse, and

the respirations are down to twelve per minute. Obstinate constipation is the last of the specially diagnostic signs to which I shall call your attention.

Before death the patient always passes into a comatose condition, the probable cause of which will be given further along when the microscopic pathology is discussed.

The reception of the disease has never been known to take place otherwise than by the stomach. The flesh, milk or butter of infected animals is the cause to which it may usually be traced, and more than one person is generally prostrated by the same cause. Sometimes different members of the same family are affected in different degrees, all the way from the worst form to that peculiar condition in which the legs are so weak as to refuse to perform their office, which last form goes by the expressive vernacular title of "*slows*."

Milch cows may give no signs of the disease until they have imparted it to their calves, or through the medium of milk and butter, have infected whole families. But there are other cases that occur in which neither the flesh of animals nor the products of the dairy have been partaken of, which adds an element of uncertainty to the supposed causes to which the disease has alone been attributed.

Further along I propose to describe what the microscope says on that point. Perhaps it would not be amiss to mention at this place some of the substances that have borne the unenviable notoriety of producing this baneful malady in animals. They are the metals Coabalt *arsenic, rhus toxicodendron*, or poison sumach, *eupatorium agertoides*, a species of weed having a white or purple top that grows in great abundance in woods and clearings almost everywhere and in localities where milk-sickness was never known. Of these substances, some occur where the disease was never known and the others are certainly absent where the disease is most known, which fact certainly eliminates all of them from the list of possible factors.

From the capability of the septic matter, whatever it might be, of pertetuating the disease in a continuous chain of animals as one should eat the flesh of another, you will see at once that any of the known organic or mineral poisons would, by a rapid system of attenuation, become harmless in the second, or at most, the third remove from the first animal eaten, which fact excludes all non-vitalized substances.

Armed with a few clean vials I started out on my collecting tour. The house where there had been two deaths still had one sufferer from the disease—a young lady. As the medical gentlemen in charge of the case were my intimate friends I did not hesitate to ask for a few drops of blood from the arm of the young lady. She was willing I should have it, but some of her friends being under the impression that the government had offered a large reward for the discovery of the cause of milk-sickness, I was, after some parleying, refused the privilege of getting the blood, for fear I might make something by it, and to clinch the matter, a neighboring man, who ought to be embalmed as the champion fool of the 19th century, oracularly asserted that three drops of blood taken from her would, without fail, kill her. However, I went to the spring—a stagnant pool from which the family used water—and took a vial of that. I then went to a farm near by where a heifer had an undoubtedly well marked case of the slows, and got some blood from her ear and hastened to my quarters at the Kaolin mine, to examine it. Perhaps it is as well for me to say here that the heifer died two days later. The blood flowed from the cut with difficulty. It was of the most intense scarlet. On submitting the blood on a slip and covering with a thin cover-glass to a Spencer $\frac{1}{10}$ objective, I was startled but not surprised to see that in the small space embraced in the field, and which could be covered by a transverse section of a fine cambric needle, there were countless multitudes of actively-moving, writhing, twisting bacteria, that bore in size and behavior a striking resemblance to that form of bacteria called by naturalists *bacilla subtilissima*. They seemed to cling to the blood disks, to be between them, to be within some of them, and to be in such an innumerable multitude as to fairly fill the observer with horror at the bare thought that the blood of even a domestic animal should have such terrible inmates. Not only I, but numbers of others saw them, and seeing were convinced. But further, some dogs ate of the dead cow and they too were attacked by the slows, and, in brief, their blood also showed the same forms of bacteria. Knowing that some of the family attacked had not eaten of milk or butter but had still suffered from the disease, and wanting a reason for it I subjected the water obtained from the spring to a like process and found that, though it appeared clear and nice to the unaided vis-

ion, it was as full of the same forms of bacteria as appeared in the blood, as was the blood itself.

Next I took some milk from a cow whose milk was used in another family where one case of the slows had occurred and found that that also showed the same living organisms as the blood and water. Since then the blood of two persons, not severely attacked has been examined microscopically and the same phenomena, only in a lesser degree were present. In size these organisms are so small that a couple of hundred might ride on the same blood disk and not be badly off for room. The blood disk, you will bear in mind, is but $\frac{1}{3200}$ of an inch in diameter. It appears to me that either the baccilla themselves, or some kindred organisms are capable of undergoing further enlargement and of laying aside their active condition and becoming matted and tangled together and of accumulating and aggregating together to such an extent as to block up the terminal capillaries and thus the cold clammy hands and feet always present in milk-sickness. The *stasis* in the lung capillaries, from the same cause, accounts for the sighing respiration, and labored cardiac action to which I alluded in the beginning of this paper.

Now that the gravity of the disease may be gauged by the numbers of those minute plants that infest it, may be promptly determined, I have no doubt, and that their presence or absence determines the fact of the existence of the disease I am fully assured.

The slows never prevail in wet seasons, when the springs are flush and the branches full. I do not assert that the water is the only place outside of animals that bacteria may propagate in sufficient quantities to cause the specific effect described, as this field is too new for such exclusiveness, but we may rest assured that if the cattle and the families have water of unquestionable purity the other sources and niduses will not be prominent factors in its production.

Gastritis and bilious fever are the only diseases that the practitioner will ever be likely to confound with slows. The treatment of slows is in itself a vindication of my pathology. Brandy and honey or syrup, and sulphur and magnesia, given in full doses every two hours, speedily produce a good effect, and convalescence soon follows the aperient effects of the latter remedies. The brandy, in bad cases, may be pushed to the extent of a pint in the twenty-four hours, and with the very best effects. One

should be positive of the disease before following such heroic treatment, as in gastritis or in remittent fever it would be apt to have grave consequences. I would like for any of my medical confreres who have good microscropes to follow up this line of investigation and address me at Bedford, Ind., giving results.

DISCUSSION.

DR. FREELAND:—Forty years ago I visited a district that suffered intensely from this disease. There is a question I would ask: How is it in these districts milk-sickness has entirely passed away? I have seen a case commencing with a cow that trembled and fell down. The cow presented no appearance of disease. In those districts where I first practiced, the country was full of it. To-day there is scarcely a case there. If it depended on water or on any one thing, how is it that it has passed away. The essayist has mentioned brandy. That was our sheet anchor forty years ago.

DR. JONES:—I want to say a few words on the pathology of milk-sickness. I have had experience for the last forty years in treating that disease. I have been of the opinion for many years that the disease was caused by a microscopic poison; a specific matter that never rises many inches from the ground; that it is deposited on the herbage, and eaten by the cattle in the morning while the dew is visible. It does not exist in clear open lands or prairies. A day or two since I was reading an article from a gentlemen in Illinois, published in the *Toledo Medical Journal*. This writer takes the position that it is a poison deposited on decomposing wood and it gets into the springs and streams so that that the water is impregnated with it at times, at other times it is not. I have long entertained the opinion that it was something of that kind generated in that way.

DR. T. F. RUMBOLD—I wish to remark that in making microcropic examinations great care should be taken to exclude the air from every specimen to be placed under the microscope. Do not take milk that is two or three days old, but take it immediately from the udder of the cow in such a manner that the air will be excluded from the specimen. Without such a precaution the examiner will be almost certain to be deceived. It is useless to examine putrid flesh for the same reason. Dr. Gardner's paper is a very important one and should be made the basis of a

very thorough microscopical examination of the blood and the secretions. The important information in this paper of Dr. Gardner cannot be overestimated.

DR. GARDNER—In reply to all of these things I would say, I do not take the position that it may not breed on vegetation where it is damp. I know it will. In reply to Dr. Rumbold I may say I took the specimen right from the living animal and put it on the slide and from the slide to the microscope, and found the bacilla there at the instant of being drawn. I mixed no fluid with the blood; it was not necessary.

DR. HIBBERD—Were there any other diseases previously, i. e., immediately before or after these cases of milk-sickness? Did you have pure water?

DR. GARDNER—No, it was at a remarkable healthy time and on a high ridge where there was pure air. The water was taken from what we call "sipes." Good, wholesome drinking water was not usually an easy thing to get. They had to take "sipe" water.

DR. RUMBOLD—Did you examine the blood of any other animal at that time that was not affected with the disease but had an opportunity to drink the same water?

DR. GARDNER—Not at that immediate time, but there was a blind horse that got down. I suspected it had the "slows." It was really a case of starvation. I got some blood of it and put it on the slide, but it showed no appearance of the disease. The old horse got his water from a spring that was near by and which looked badly.

DR. HIBBERD—In 1841 I was sent for to go about ten miles from my office to see a patient that was said to be very sick. It was a flat country in which so-called malarial diseases are very prevalent. On the road going to the sick man, the messenger told me the patient had milk sickness, and I had been sent for because of my reputation in curing that disease. That was agreeable news! I had *never* seen a case of milk-sickness; did not know how to cure it any more than the man in the moon, but as I had obtained a reputation, it was agreeable news. The trepidation we sometimes experience passed off and I was shown the house where the sick man lay. I had treated several cases of malarial fever in that locality and this, I found, had established my reputation as an expert doctor in milk-sickness. I was in a part of

the country where malarial diseases were rife every year. I found the man's case just the same as the others and I should not have thought it was milk-sickness unless I had been told so. I do not say there was constant vomiting but he vomited and I treated him successfully. I treated a large number of cases in that neighborhood, only two of which died and that resulted from broken down constitutions, brought on by whisky drinking. Usually there was not much trouble with these cases, but if the constitution was broken they gave way. I wrote a paper the following year on milk-sickness and it was published. I took the view that it was of malarial origin. Still there were some peculiarities about it that took it out of the category of malarial fever. It should be described as malaria with something added. The paper read this morning, it seems to me, is a superb start for an investigation. The author seems to me to generalize from too narrow a foundation, to draw too large a conclusion from the observation made. It needs to go a great deal further, but if it turns out that it is bacteria or some other organism in the circulating fluid in animals and man, why we will have made immense steps in deciding what this extraordinary disease does grow out of. I will say in conclusion, I think the author of the paper deserves our thanks for the beginning he has made in this direction. I hope he and others will continue the investigation from year to year. Then we will have a foundation from which to start with perfect safety so as to get at the origin of the disease.

DR. BREY—What is the pathology of this disease? A great deal has been said about the cause of the disease, but nothing about its pathology. When I came here in the fall of 1835, this disease prevailed in this section of country, as it did in other parts of this State, Kentucky and Illinois. I was associated with Dr. Crafton, a man of extraordinary mind. He made several post-mortem examinations of persons who died of milk-sickness. In every case there was inflammation of the mucous membrane of the stomach, and if the disease was not arrested in its progress it extended from the mucous membrane of the stomach to the bowels. The pyloric orifice was particularly implicated. He states it was occasioned by a specific poison, and that it spent its force on the follicles of the mucous membrane of the stomach. It is seldom you see an acute case in this disease; it is generally of a low typhoid character, indicating a poison that spent its force upon the blood.

FRACTURES OF THE SPINE, WITH CASES. By J. R. WEIST, M. D., of Richmond, Ind.

When we consider the irregular forms of the vertebra, and the overlapping of their various processes, we can readily understand why, when violence greater than the spine can withstand is directed upon it, and it yields to the force, the injury is generally of mixed character, consisting of both fracture and dislocation. This is more likely of course to be the case in some portions of the spinal column than in others. "In the dorsal region the bones are so closely locked, and the processes, especially the spinous, so long and overhanging, that simple dislocation appears impossible."

While Malgaigne and others report dislocations of the dorsal vertebra, a consideration of the anatomy of their processes will render it apparent that even a partial laxation forwards without a fracture of the oblique apophyses is impossible, and that backwards, the luxation can only occur to the extent of about one-quarter of an inch (Hamilton), constituting only a species of articular diastases, without breaking off the articulating apophyses of the lower corresponding vertebra.

As a practical question the proportionate amount of fracture compared with dislocation, in serious injuries of the spine, is of little moment. The question of great interest to the surgeon in these cases is the condition of the spinal cord, and this organ can be crushed or have its functions destroyed equally by fracture or dislocation. Besides, if a reduction of the displaced bones is attempted, the method of effecting it will be the same in both cases, and the prospect of recovery is not more encouraging in the one case than in the other; therefore, in the cases I shall report, no great effort was made to determine the relative amount of fracture and dislocation.

As already intimated, the great danger in these cases arises from injury to the spinal cord, and it is easy to understand why this organ can hardly escape serious damage, when there is extensive fracture or dislocation. As any extensive lesion of the cord is attended with paralysis of parts below the injury, the gravity of the accident, so far as endangering life is concerned, varies

with the part of the spine injured. The higher the injury, the greater the danger.

In most cases of fracture or dislocation of the spine, there is paralysis, more or less complete in the parts below. Yet there are well authenticated cases in which it was absent.

The danger arising from compression, or injury to the cord, is so great that generally surgeons advise that no effort be made at reduction in these cases, even when there is great deformity, from a fear that it will result in a further injury to the cord. But this rule of non-interference cannot apply alike in all cases. When the injury is at, or above the fourth cervical vertebra, any serious injury to the cord means instant death. When, therefore, any displacement of the bones in this part of the spine exists, an attempt at reduction cannot be made without serious consideration, as it may result in the sudden death of the patient. When, however, the injury is in the lower dorsal, or lumbar region, it must certainly be often proper to attempt reduction—although the weight of surgical authority is perhaps against it—and for several reasons. First, because a number of cases have been reported in which reduction has been successfully accomplished. Second, because proper efforts are not likely to make the existing trouble worse. Compression of the cord here does not mean death, so there is no danger of suddenly killing the patient while seeking to render him a service.

When there is incomplete paralysis, it is evident that only slight injury has been done to the cord — either from concussion or slight pressure. If paralysis depends upon the first cause, it will probably soon disappear; while if from the second, a replacement of the bones will likely relieve the compression. While in these cases of complete paralysis, irreparable damage has most likely been already done, and our efforts cannot make matters worse, I believe then that Hamilton indicates the correct method of treating these cases, when he says: "I think we cannot hesitate when the nature of the accident is fully made out, and especially when the dislocation or fracture has occurred in the lower dorsal vertebra, to attempt the reduction by forcible extension, united with judicious lateral motion or with a certain amount of direct pressure upon the projecting spines."

The two following cases are presented for the purpose of contrasting the results of the two plans of treatment. As will be

observed the injuries are of very similar character, and therefore the cases serve well the purpose intended.

On March 22, 1878, I was called to see Mr. C., aged about 21, who had been injured by the falling of an elevator in one of our manufacturing establishments. While standing under the elvator in a stooping position, the rope supporting it gave away—it was at the time loaded with a quantity of lumber—and he was caught and crushed to the ground. When I saw him, he had been removed from the wreck, and laid on a board. He was only partially conscious. I found an injury of the back at the tenth and eleventh dorsal vertebra. There was marked angular curvature at this point, caused chiefly by projection of the spinous process of the tenth dorsal vertebra. There was nearly complete paralysis—both of motion and of sensation—in the body below the injury. There was decided disturbance of respiration, this being quick and jerky. In addition to the injury described, there was a serious comminuted fracture of both bones of the left leg. The deformity of the back was so great that the bystanders recognized that it was broken. They of course were possessed by the popular idea that this meant death.

I had the young man carefully conveyed to his home, on the board, and placed in bed with as little disturbance as possible, no effort being made to correct the deformity of the back. The leg was dressed at first with Pott's splint, and afterwards with plaster Paris bandage. Great pain at seat of injury in the back was complained of for many days; this was greatly increased by any motion of the body. The respiration hardly improved for ten days. It was necessary to employ the catheter to empty the bladder, for three weeks. After about two weeks there was gradual improvement in the paralysis—sensation returning before motion—but it was four months before it had nearly passed away, and he could be out of bed, and move about a little on crutches. By careful management, no bed sores of consequence—that are often so troublesome and dangerous in these cases—formed. The injury to the leg was perfectly repaired without unusual difficulty.

After several months the crutches were laid aside, and there was gradual improvement. Now, about sixteen months after the accident, he is just beginning to be able to do a little work. No paralysis remains, but the back is weak and at times painful. The curvature of the spine and the projection of the spinous pro-

cess of the vertebra remains very nearly the same as at the time of the accident. As these cases usually terminate, this may be considered a remarkably good result.

June 25, 1879.—I was called to see Mr. B., a healthy farmer, æt. 30 years, whose back the messenger said was broken. The accident had occurred in this manner. He was on top of a load of hay that was being driven under a shed across which some beams were placed. As he was passing under the shed he discovered that he was likely to be caught by the timbers above. He was sitting down on the hay; he threw his body forward and lowered his head; still there was not sufficient room, and the upper part of his shoulders and spine came in contact with the obstruction above, and he was badly crushed. He was unconscious for some time after the accident. The discovery was made that there was a serious injury with great deformity of his back. When I saw him a few hours later, he was in great agony, complaining of violent pain in the back, and of great difficulty in breathing.

On examination I found evidence of great shock, pulse being 140, and very feeble. The skin cool and bathed in perspiration; respiration 35, and difficult; marked deformity of the spine was found at the 9th and 10th dorsal vertebra. On each side of the spine there was decided swelling near the point of curvature. At the upper part of the shoulders, the skin was abraded and much bruised.

There was partial loss of sensation below the seat of injury, more marked on the right than on the left side. No paralysis of motion seemed to exist. As any motion of the body produced the most agonizing pains in the back, ether was recommended. The clothing was removed and some further examination was made of the injury. The spinous process of the 9th dorsal vertebra was much displaced backward, it being possible to distinctly place the finger under it. The examination rendered the conclusion inevitable that there was fracture with slight dislocation backwards of the ninth dorsal vertebra; some effort by extension and pressure was made to reduce the displacement, with but slight success. During these maneuvers distinct bony crepitation was felt. Anodynes and stimulants being ordered, the patient was left for several hours until he recovered from the shock.

Upon visiting the patient again, some fifteen hours after the

accident, reaction was found pretty well established. The respiration, however, was not improved, and the pain only kept in check by the anodynes; paralysis about the same. I now determined to institute more active measures. He was carefully lifted out of bed, and held erect while a tracing of his spine was made. He was then suspended a la Sayre, by an improved apparatus, that answered the purpose well. While he was completely suspended, I passed one arm aronnd the body just above the hips and made strong extension with slight rotatory movements; at the same time with the other hand I made pressure at the injured and projecting parts of the spine. These efforts resulted in straightening the spine very materially, as will be seen from the second tracing made afterwards. While the extension and pressure were being made, a very distinct bony crepitation was again felt.

The plaster jacket was now hastily, but carefully applied. As soon as the plaster was sufficiently firm, he was taken down and placed in bed. After he had recovered a little from the exhaustion caused by the suspension, all this being done without ether, it was found that his breathing had greatly improved, the bladder having been relieved and a slight anodyne given; he was left in comparative comfort. On my visit next day, his condition was greatly improved, the respiration being perfectly free and easy, with restoration of sensation to parts below the injury; the bladder had been relieved naturally. He could now be rolled over with little pain resulting, and could lie either on his back or his side.

Steady improvement continued; on the seventh day he could turn himself in bed without assistance, and on the twelth day he was carried on a stretcher to his father's house, about two miles distant. On the fifteenth day he was able to slowly work himself out of bed and stand on his feet. On the twentieth day a new jacket was applied and worn until September 1st. November 2d sixty-seven days after the accident, his back is as strong as before the injury.

The plaster jacket proved in this case to be a splendid apparatus. Probably no other form of dressing could have accomplished as much in the way of rendering the patient comfortable, and none certainly could have secured a more perfect result.

When I applied the plaster dressing in this case, I was not

aware that it had been used in such cases, but I learn from Prof. Sayre that it has been used in a similar way several times in the Bellevue Hospital, with very satisfactory results; probably others also have thus used the plaster jacket. However this may be, I make this report at the request of Prof. Sayre, and in doing so fully indorse his statement, that "the plaster jacket is the only form of dressing that has been yet devised that will keep a fractured spine perfectly at rest."

DISCUSSION.

Dr. Freeland—A case occurs to me in the person of my own son. The fourth cervical vertebra was broken laterally, it projected fully half an inch. There was no paralysis. I refused to allow any interference with it. I determined to leave it to nature. It is now twenty-five years since it happened. He is now a strong, able-bodied man.

Clinical Reports from Private Practice.

Early Menstruation. By J. W Foster, M, D., of Kansas City, Mo.,

In October, 1878, while traveling in Southwest Mo., my attention was called to a very interesting case of early menstruation The child, then about two years old, had been menstruating some five months, the discharges occurring at regular intervals of three and a half weeks. There was nothing unusually present in the case with the exception of the early age of the patient. Her father was very much exorcised about the welfare of his little daughter and his solicitations ever very earnest as to the future probability of the case. He had consulted many of the local physicians and they had never seen an example of so early menstruation before. I assured the father that he need not be apprehensive of any immediate or remote danger, as the child was as healthy and perfectly developed as Venus de Medici. More than fourteen months have now elapsed since this case came under my observation and the child has remained perfectly healthy ever since. She continues to menstruate with all the phenomena pertaining to this function. Her breasts are

showing signs of advanced development and the pudenda also well coated with a soft silky hair, showing unmistakable signs that she is susceptible of impregnation. Another peculiar expression in the character of this child at the present age is a marked shyness or timidity fully expressing the womanly decorum and manner, which we so ardently admire in the gentler sex. In 1870, I saw in Cincinnati a case similar to this one. In that instance the child began menstruating at the age of seventeen months and when I saw her she was twenty-seven months old and presented all the features of a girl fully arrived at puberty. I have been unable to learn anything of the subsequent history of this last mentioned case, from the fact that in the spring of '70, her parents took her to Germany, they being Germans. It was their intention to visit the various medical schools and hospitals of Europe, and exhibit this early freak of nature.

Encephaloid of Left Kidney. By E. A. Waggener, M. D., of Carrollton, Mo.

Boy æt. three one-half years, a farmer's son; family history good, health good up to June last.

In harvest time, the exact date not known, he came in from the horse-lot one day and stated to his mother that a colt had tramped on him and he complained of a 'hurting' in his left side in region of kidney. His person was examined, but no marks found; notwithstanding the child continued to complain of pain in the locality mentioned and after a lapse of a week or ten days a 'lump' was discovered where pain had been located.

The patient was carried to a physician and put upon a course of treatment. Tumor continued to enlarge very rapidly and about the 1st of October boy was brought to our office for examination by Drs. Austin, Cooper and myself. At that time the tumor filled left iliac fossa, extending up to the ribs and forward and one inch to the right of the median line, filling completely all the space within this area; smooth, irregularly ovoidal, elastic or semi-solid feel; constitutional effects plainly visible. We were not able to promise the parents anything in the way of successful treatment, though the case was not ours, and we afterwards learned that it passed into the hands of a homœopathic doctor who had charge of it up to time of death, which occurred at 7 P. M. on the 21st inst. At the request of the family, Drs. J. C. Cooper, W. A. Tull and myself made post-mortem examination at 9 A. M. the following day. I will only describe in brief the appearances inside of the abdomen, viz. Tu-

mor filled the entire cavity, producing enormous distension, pushing diaphragm up to the fourth rib on each side, and adhered to the spleen, pancreas, stomach, diaphragn; on the left side portions of small and large intestine, the descending colon being on the anterior surface of the tumor and one and one-half inches to the right of the median line and firmly adhered. In fact the tumor was adhered to everything in the left half of the abdominal cavity; spleen and right kidney healthy in appearance, though the spleen is smaller than normal; left lobe of the liver normal except in size; right lobe very much contracted; black-mottled and studded with numerous abscesses from the size of a three cent piece to a quarter of a dollar. Tumor removed by enucleation except in immediate vicinity of the left kidney, where adhesions were so firm that dissection had to be resorted to. Appearance after removal: Irregular ovoidal, nodulated, mottled-purplish and very vascular, and some places almost black, resembling mellinosis. Measured 9½ inches in its shortest and 11½ inches in its longest diameter and weighed 9½ pounds. On section the pelvis, a few pyramids and a considerable quantity of cortical substance of the kidney was found at the base of the tumor, thus fixing beyond doubt its origin.

GRADUATING EXERCISES OF THE ST. LOUIS MEDICAL COLLEGE. THE LIST OF GRADUATES. A SYNOPSIS OF PROF. J. T. HODGEN'S ADDRESS TO THE CLASS, AND THE PRESENTATION OF A CADUCEUS TO HIM BY DR. C. W. STEVENSIN BEHALF OF DR. CALVIN M. CASE, ONE OF THE GRADUATES.

The exercises were opened by prayer by Rev. W. G. Eliot, president of the board of trustees. The degrees were conferred by Prof. J. B. Johnson with appropriate remarks.

The following are the names of the graduates:

J. S. Deaderick,
Calvin M. Case,
E. F. Hauck,
Louis Hauck,
Douglas C. Ramsey,
W. J. Wait,
Sutton W. Pilley,
John A. Hornsby,
Thomas A. Smith,
John C. Welch,
George A. Auerswald,
George W. Farrer,
Ralph Staples Bragg,
E. F. Fiedemann,
Wm. S. Hutchinson,
Fred. G. Zenk,
Elhanon Chinn,
Augustus S. Chouteau,
Benj. F. Holcombe,
Hugh L. Gault,

A. H. Ohmann-Dumesnil,
G. M. Stelzlini,
R. J. Stoffel,
Thomas H. Ensor,
John McG. Oglesby,
Wm. T. Gerisch,
Squire H. Redmon,
E. A. Junkin,
Joseph R. Hollowbush,
John B. Leffingwell,
George W. Toney,
John L. Sims,
Dodson Christian,
Phineas K. Dow,
Chas. F. W. Wilhelmj,
Fred. L. Loring,
Fred. S. Dewey,
George F. Hulbert,
August F. Wohlfarth,
Fred. O. Meyer,
Otto C. Meyer.

DR. HODGEN'S ADDRESS.

I may be permitted to introduce the subject of my remarks this evening with the question, Whence come the responsibilities that attach to living beings?

In order that I may be understood, I would go far back to the lower forms of living matter, and call your attention to the fact that lying thousands of feet beneath the ocean's surface, at its very bottom, is a layer of living matter—a material which possesses attributes common to other living matter. It gathers from the material which surrounds it the elements necessary for its maintenance and growth. It absorbs, it circulates, it is nourished, it grows. It breathes, it eliminates, it has a power of changing form and changing location. It is called bioplasm. But it has no means of bringing itself in contact with objects outside of itself; it has no organs of special sense. It bears no responsibility growing out of relation to the existence about it. It lives without pleasure and dies without pain.

There is one word which I have occasion to use this evening that may not be familiar to every individual of this large audience. The word is differentiation. The very expression conveys to your mind an idea of difference. It means the changing form or character. This term is applied not only to the forms of matter, but is applied to the functions exercised through the change of matter, so that we have a differentiation, not only in living forms, but in the performance of the offices of living beings. It means a division, not only of structure, but a division of function. It means a division of labor. By it it is made possible that the varied functions performed by the living matter to which I have already called your attention, (which forms a stratum on the bed of the ocean), instead of being performed by the simple material, structureless, homogeneous bioplasm without line or fibre, without special organs, the offices of digestion, of assimilation, of respiration, of nutrition, of growth, of elimination, of motion, instead of being performed by one common mass, are performed by organs specially designed, each for its own special office. Thus we have in higher forms of living being a digestive apparatus, by which the materials ta-

ken as food are brought forward in a certain condition of change, rendering them more easily taken up by the vessels which are to carry them to the parts to be nourished. We have a circulatory system which does the transportation duty. We have a special breathing apparatus, a special locomotory apparatus, and special organs for elimination of effete and worn out particles, and by this multiplication of organs, we have a very much more perfect organism than is represented in the simple bioplasm, but in order that these diverse parts performing different functions, working harmoniously in the building up and maintenance of an organism, and the execution of its varied functions, it is necessary that there should be a link binding the parts to form one harmonious whole; and this link is furnished in the nervous system.

That you may understand more clearly what shall follow, we must tax you with a reiteration of a little rudimentary anatomy. As the lowest form of independent nervous mechanism, we have the simple nervous arc, consisting of a fibre beginning in a sensitive surface, and terminating in a mass or knot of cells or granules, called a ganglion, and a second fibre reaching outward from this ganglion and terminating in an organ of motion. The office of such a simple nervous arc is, that if an irritant be applied to the sensory surface it produces an impression, which is transmitted by the afferent nerve to the ganglionic centres, and radiated from that point to the organ of motion through the efferent fibres.

And the peculiarity of the action resulting, is that it is always in direct proportion to the stimulation. It never goes beyond a certain fixed point. A little higher in the scale of the nervous mechanism we have another series of ganglia, with connecting fibres similar to those which are described as belonging to the simple nervous arc, but in addition, other fibres connecting various ganglia with each other which are themselves connected with various organs of locomotion. This more complex mechanism is capable of more complex functions, and if an irritant be applied to the termination of the sensory nerve, we have a response, not always the same and not always precisely in proportion to the stimulation applied.

This is well illustrated in the action of the spinal cord of the decapitated frog, which, when the flank be tickled or irritated, moves the hind foot of the corresponding side through the successive action of a variety of muscles, to accomplish a movement which would result in sweeping from the part irritated, the irritating object. This may be repeated again and again and the same movement that follows in the action of the same limb will be accomplished. But if that limb be held and the stimulus be continued, then another limb will be brought into action and this will be made to go through the movement which would be necessary to remove the irritant.

This sort of action may be called automatic. It is not always

the same character of movement, but it is always designed to accomplish a purpose. It is accomplished by the mechanism, and without volition, without knowledge, without the influence of any of the higher nervous centres that may belong to a more complex nervous system.

Farther on we have volitional centres; those through which the will controls the automatic actions of the automatic centres, and the simple reflex act of the simple nervous arc.

Beyond this and above all, we have what may be called rational centres; centres through which the reason acts. First upon the volitional centres; secondly, through the automatic centres. On a side track in the nervous chain and connected by a switch (if we may use the expression), which leads off from the main track at the volitional centres, we have situated the emotional centres; those centres through which the feelings are operative—through which hate is expressed, or fear, or anger, or envy, or love, or any of the emotions. Most of our actions are automatic. Thus the spinal cord walks though the volitional centres and the rational centres may be otherwise occupied.

The student walking to school in the morning may study his lessons very carefully, whilst the automatic centres will carry him safely down grade, over the level street, across gutters and up hills and around obstructions as perfectly as though the mind were directly engaged in the act of locomotion.

So also the act of talking is automatic. The reason determines that something is to be said, and without thinking of the language to be used, a sentence is framed which may fitly express the thought that has been entertained, and all these centres are susceptible, indeed, are dependent for their highest capabilities of action upon education. Hence the importance of educating, not only the rational centres, but the emotional centres, and educating them in the right direction; for unfortunately education does not always mean a cultivation in the direction which renders us capable of the greatest possible good.

We allow ourselves to become annoyed by trifling matters, and we allow our emotional centres to use our organs of speech in an automatic way. We acquire habits of complaining and have a word of censure for whatever may attract our attention. On the other hand, the automatic centres may be so trained that a word of approval will be uttered, on whatever may be presented to us. Often excuses for the irregularities of others are formed and expressed by those who have cautiously educated the automatic centres of speech.

I have already mentioned that the emotional centres are placed on a side track and that these as well as the rational centres are connected with the volitional centres, and there is often a struggle between the one and the other. How often do we find the emotional centres to exercise the power which determines the action rather than the rational.

So far as possible the emotions ought to be held in subjection to the reason, and by careful cultivation this may be accomplished. Without it the emotions are very sure to carry us out of the way of accomplishing the greatest possible amount of good.

To these centres we have added organs of special sense; of touch, of smell, of hearing, of taste, of sight, and these bring us into relation with the surrounding world. They make us the associates of those about us, and these organs of special sense, together with the ganglionic centres to which I have referred, makes us responsible to ourselves and to those who are about us.

Connected with these ganglionic centres, but more nearly related to the emotional than to any other to which we have called attention, we might mention the possible existence of a certain class of emotional centres that bear more directly on our relations to a Supreme Being. These may be called devotional centres, and through their action we are made to feel the obligations and responsibilities which are forced upon us by the relations which we sustain to the Creator.

Having thus far traced a mechanism through which man is made responsible, and hinted—that the ganglionic centres are susceptible of cultivation—we may go still further in the matter of differentiation, and still increase our responsibilities.

Through the exercise of the will, we may determine when we will differentiate in one direction or another. One man becomes a shoemaker, one a tailor, one devotes his attention to the law, another studies for the ministry, and the fifth becomes a physician, and with the multiplication of offices the possibility of a perfect association and action are rendered more easy.

The possibility of living comfortably is brought within our reach by the multiplication of occupation. Nothing is truer than that a "division of labor is the secret of wealth." It is just as true that the division of labor among individuals is the secret of elevation as it is true that the division of labor among the organs of the body is the secret of a more perfect organism. If, then, with this ultimate differentiation, you gentlemen of the medical class have assumed relations to society which puts you in charge of the health of the community, of the lives of the community, and therefore very largely in possession of the happiness of the community, your responsibilities must be very great.

The process of differentiation does not cease with the division which I have already given, but even in our own profession we have a still further dividing up of the duties that belong to us. We have the oculist and the aurist, the laryngoscopist and the gynæcologist and others. It is certainly true that one who devotes his attention to the cultivation of a particular branch of our profession, is, other things being equal, more competent than one who has not thus given his special attention to the cultivation of the particular part. But it is equally true that one

who attempts to differentiate before he has reached a certain stage of perfection in general professional attainments, must fail to attain the success he desires. Therefore, I beg you wait until you have acquired a very thorough knowledge of the general profession before you begin the process of differentiation that may make you an oculist, an aurist, a laryngoscopist, a gynæcologist, for so sure as the attempt is made without this proper foundation, the differentiation must result in your degeneration into quackery, or your utter failure in the practice of your specialty.

I will not, at this last hour, advise you as to the means of meeting the many responsibilities that lie thickly along the pathway of a physician's life. I will only call your attention to one or two points, without a consideration of which it seems to me impossible that you can approach to anything like a perfect discharge of the fearful responsibility that you have taken upon yourselves, in assuming the practice of our profession. Is it possible to conceive of one more degraded than a physician assuming the responsibility of the health, of the life and the happiness of his patrons, who is not honest? Be honest with yourselves; be honest with your patrons; be honest with God.

If the fearful responsibility to which I have already called your attention, rests upon the physician, how important it is that we should be ever ready to meet it! How gross a piece of folly it would be that he should put himself in a position where he can not possibly do, at all times, the very best that may be done for those who may be left in his charge.

I have heard it said until I am sick of the saying, and you will hear it said again and again until you are nauseated to a degree equal to that which I feel, "That is an excellent physician. I am sorry he drinks."

Is it possible that a man who puts himself in a position to be unfit to discharge the highest duties which man is called upon to discharge should so debase himself as to become intoxicated? Is it true that any man who ever becomes intoxicated is a good physician? It is utterly impossible that he should be. He is deserving the contempt and the scorn rather than the patronage of those who are about him.

You young gentlemen perhaps anticipate that I may say one word that may be an index, a guide to success. I can give you an index in little more than a word. That you may be successful, it is only necessary that you so fit yourselves by the cultivation of reason, by the storing of your minds, by the education of your nervous centres, that you will merit success in your profession. Nothing is surer than success to any individual who may merit it.

In behalf of the Faculty of the St. Louis Medical College I bid you God speed.

PRESENTATION OF A CADUCEUS TO DR. HODGEN.

Dr. Stevens said: It is made my pleasing duty to pass to you this caduceus—the magic wand of Mercury. The wand with the serpents entwined, according to the story in ancient mythology, was given to Mercury by Apollo. The serpent symbol, from time immemorial, whether in the hand of Apollo, or on the staff of Æsculapius, or drinking from the cup of Hygeia, or coiled upon the wand of Mercury, or as in modern times, in the coat of arms of savans, has always been regarded as an emblem of wisdom, of health, life and power, and particularly associated with the art of healing. The donor of this beautiful gift—a member of this class, Dr. Calvin M. Case—intends this as a high and delicate compliment to yourself; and it is a compliment I am sure you will not fail to understand and appreciate, and let me add, one which, in my opinion, no one better deserves.

REPLY OF DR. HODGEN.

I know not how well fitted I am to be the recipient of this high compliment. Whether I deserve it much or little has been largely determined by the gentleman who has been called upon to present it.

For more than thirty-five years he has been my friend, and, strange as it may seem, partly through his influence I have followed him, first in the occupancy of the place of Demonstrator of Anatomy in the medical department of the University of the State of Missouri, and afterwards as Professor of Anatomy in the St. Louis Medical College.

For his flattering expressions I am grateful, and to the kindly feeling of the thoughtful donor, I am also grateful, and especially so, since Dr. Case, who bestows this wand, is our professional grandson.

Editorial.

The history of Italian medicine, which appears in the pages of the JOURNAL of March 5, is the commencement of a series of papers on this subject translated from the Italian by a gentleman well known to North American medicine. The pen of Dr. Joseph Workman has often delighted and enlightened the profession both in the productions of his own, and in the translation of others' thoughts and observations.

In a letter to us of last January he says: "It seems to me a pity that our young men of to-day should know so little of their indebtedness to the fathers of anatomical and surgical science, and especially to those of the great schools of Italy. Not very

long ago a young practitioner, fresh from the London Hospital, observed to me that the Italians had never contributed much to our literature. I said little, for as Quintilian said, 'We cannot fill bottles with wine unless we empty them of their contained air.' So is it with man's ignorance; knowledge can enter only as escape is given to ignorance, and pricking their gas bags is a pretty sure way of provoking their dislike. I have seen some instances of this mishap in my long days, and I now hesitate and ask myself *cui bono?* An old English or French proverb says:

'Send a goose to Dover
It will come a goose over.'

We send some goslins over the big pond and they come back big ganders, but they strut very happily."

Dr. Workman's linguistic attainments are not alone confined to the Italian. He has given to the profession many excellent things from the Portugese, Spanish, French and German. Among the latter may be named the excellent writings of the great Grissinger and Schroder Vander Kolk. Dr. Workman is now President of the Toronto Medical Society, and for many years was Superintendent and Physician of the Toronto Asylum for the Insane, an institution rendered famous throughout the Canadas under his able administration.

The *Chicago Medical Gazette* comes to us laden with good matter. We presume that it has a larger amount of editorial matter than any journal in the West. The opinions contained in these editorials are in the main sound, but our esteemed Lakeside cotemporary is considerably "off" on the subject of lunacy "reform." It makes mistakes in stating that the number of attendants *per capita* in hospitals for the insane is smaller than in general hospitals; that the management of the insane is in violation of the rights of American citizenship, and that asylums ought to have stewards (vide page 26), by which we infer that the *Gazette* does not know that every hospital for the insane has a steward.

We know of no State where the insane are sent to the hospital without a due process of law,—that is, on the certificate of two respectable physicians recognized in law; no State where they are deprived of their rights of *habeas corpus*, and none in which lunatics are regarded as citizens.

Books and Pamphlets Received.

Posture in the Treatment of Intestinal Colic and Ileus; with a consideration of the Pathology of "Spasmodic Colic." Being the Supplement to a paper read before the New York Academy of Medicine, May 1, 1879. By Frank J. Hamilton, M. D.

The Structure and other Characteristics of Colored Blood Corpuscles, By Louis Elsberg, M. D. [New York, G. P. Putman's Sons, 182 Fifth Ave. 1879.]

The Therapeutics of Gynæcology and Obsterics, Comprising the Medical, Dietetic, and Hygienic Treatment of Diseases of Women, as set forth by distinguished contemporary specialists. Edited by William B. Atkinson, A. M., M. D., pp 365, 8 vo. [Philadelpia: D. G. Brinton, 115 S. Seventh st., 1880.]

Elements of Chemistry. By Adolphe Wurtz, Translated and Edited, with the Approbation of the Author, from the Fourth French Edition, by Wm. H. Greene, M. D., with one hundred and thirty-two illustrations. pp 687, 16 mo. [Philadelpia: J. B. Lippencott & Co.; London: 16 Southampton street, Covent Garden. 1879.]

Eyesight: Good and Bad. A treatise on the exercise and preservation of Vision. By Robert Brudenell Carter, F. R. C. S., with unmerous illustrations. pp 265, 12 mo. [London: Macmillan & Co. 1880.]

Malaria and Its Effects. By J. W. Younge, M. D. [Fort Wayne, Ind., 1880.]

Clinical Notes upon the use of The Galvano-Cautery. By William A. Byrd, M. D., etc., Quincy, Ill. Reprinted from "The Practitioner," January, 1880.

A Manual of Pathological Histology. By V. Cornil and L. Ranvier. Translated, with Notes and Additions, by E. O. Shakespeare, A. M., M. D., and J. Henry Simes, M. D., with three hundred and sixty illustrations on wood, pp 784, 8 vo. [Philadelpia: Henry C. Lea, 1880.]

The Hypodermic Injection of Morphia. Its History, Advantages and Dangers. (Based on the experience of 360 Physicians) By H. H. Kane, M. D., New York, pp 364, 16 mo. [New York, 1880.]

A Manual of Auscultation and Percussion, embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By Austin Flint, M. D. Second edition, revised, pp. 240; 12 mo. [Philadelpia: Henry C. Lea, 1880.]

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Berberis Aquifolium.—From California. Has marked alterative and tonic powers, and has been used with extraordinary success in salt rheum, psoriasis, eczema, scrofula and syphilis.

Black Haw.—(Viburnum Prunifolium.) From the United States. Employed to prevent abortion and miscarriage.

Grindelia Robusta.—From California. A valuable curative agent in asthma and diseases of the air passages.

Grindelia Squarosa.—From California. Anti-malarial. Used in enlarged spleen and other malarial diseases.

Cereus Bonplandii.—(Cereus Grandiflorus and Cereus McDonaldii.) From Mexico. Heart sedatives. Very useful in controlling functional and organic disturbances of the heart.

Kaki.—(Dyospyros Kaki.) From Japan. Peculiar action on the mucous surfaces. Useful in mucous dyspepsia, typhoid fever, etc.

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